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Health Benefits University
Commonwealth of Massachusetts

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Executive Office of Elder Affairs

Jane Swift
Governor

Lillian Glickman
Secretary

Editors: Mary Kay Browne & Marion Aspinall

We are grateful to the many people who provided assistance in the development of this training, and to the Trainers of the SHINE Program and the Medicare Advocacy Project.

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October, 2001

Welcome to the 2001 Health Benefits University! The materials for Health Benefits University were prepared for you by the SHINE (Serving the Health Information Needs of Elders) Counseling Program of the Executive Office of Elder Affairs to support you in your work with elders. The tools were designed to be practical aids you can use to:

- screen individuals for public benefits programs;
- understand when someone has a special enrollment period to buy a Medigap policy;
- know when and how to initiate an appeal to safeguard a Medicare benefit;
- supply basic information when someone needs to take action because their premiums increase, their managed care company leaves the area, or their primary care doctor leaves their HMO; and
- learn how MassHealth Waiver Programs work.

Health insurance can be a very complicated subject. The SHINE Health Insurance Counselors help elders and their families navigate through the health insurance maze by providing free one on one counseling. We hope this informational material and training gives you a more comfortable command of the subject and greater skill communicating with elders dealing with complicated situations. Please read the SHINE Program's quarterly newsletter, *"Your Medicare Expert"*, for ongoing updates on health insurance and benefits issues.

On behalf of Governor Jane Swift, Mass Home Care and the Massachusetts Association of Council on Aging and Senior Center Directors, I wish to thank the SHINE Regional Directors and Counselors as well as staff of the Aging Service Access Points and Councils on Aging for their dedication and commitment. We thank you for the excellent work you do as an elder advocate in Massachusetts. The quality of life for Massachusetts elders is enhanced and protected by your efforts.

Sincerely,

Lillian Glickman

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Medicare Information for Massachusetts Residents

State Health Insurance Assistance Program For Massachusetts

The Serving The Health Information Needs of Elders Program
The "SHINE" Program

In Massachusetts, the Serving The Health Information Needs of Elders (SHINE) Program helps seniors understand how to get the most out of their health insurance options. SHINE's Health Insurance Counselors work face- to-face, free of charge, with people who need help with:

- Understanding Medicare
- Buying a Medigap policy
- Understanding managed care plans/HMOs
- Filing claims
- Fixing billing errors
- Appealing Medicare denials
- Filling out applications

All SHINE counseling and assistance is free and confidential

SHINE's Health Insurance Counselors can meet with you in many local sites, such as Councils on Aging, libraries, hospitals, or in your home. To make an appointment with a counselor, simply call your local Council on Aging and ask for a meeting time.

Health insurance for Medicare beneficiaries can be very complicated. SHINE's Health Insurance Counselors must go through a 8-day training before they are certified to assist you.

The training covers:

- all of Medicare's benefits
- Managed care/HMOs
- Medigap insurance
- MassHealth (Medicaid)
- Drug benefit programs, including the Prescription Advantage
- patient appeal rights
- how to pay for long term care
- insurance options for older persons
- aged 60-64 who are too young for Medicare.

Call the SHINE Program for any questions you may have about your options for securing health insurance, managing claims under your current coverage, or appeal rights.

State-wide SHINE Office:
1-800-AGE-INFO
1-800-243-4636
TTY (hearing impaired):
1-800-872-0166

The Shine Program is funded and coordinated by the Executive Office of Elder Affairs in partnership with elder network agencies across the Commonwealth of Massachusetts. Partial funding provided from CMS.

Medicare Preventive Services...

...To Help Keep You Healthy

There are steps you can take to lower your risk of disease and illness. Medicare is providing coverage for these preventive services to help you stay healthy. Medicare will cover:

- Tests for breast cancer, cervical cancer, vaginal cancer, and colorectal cancer;
- Bone mass measurements;
- Diabetes monitoring and diabetes self-management;
- Flu, pneumonia, and Hepatitis B shots; and
- Prostate cancer screening tests.

These valuable benefits from Medicare may be the key to long lasting good health. Talk with your doctor about your risk of developing these health problems and your need for these preventive services.

This pamphlet includes:

- A chart that explains which preventive services are covered by Medicare, for whom they are covered, and what you pay.
- Cards with more detailed information on some of the preventive benefits. You can tear these out and put them on your calendar or refrigerator as a reminder, or you can take them to your doctor so that you can talk about the preventive services that Medicare covers.

ed Service

Bone Mass Measurements:
Varies with your health status.

Colorectal Cancer Screening:

- **Fecal Occult Blood Test** - Once every 12 months.
- **Flexible Sigmoidoscopy** - Once every 48 months.
- **Colonoscopy** - Once every 24 months if you are at high risk for colon cancer. Starting July 1, 2001, once every 10 years but not within 48 months of a screening sigmoidoscopy if you are not at high risk for colon cancer.
- **Barium Enema** - Doctor can decide to use instead of a sigmoidoscopy or colonoscopy.

Diabetes Services:

- Coverage for glucose monitors, test strips, and lancets.
- Diabetes self-management training.

Mammogram Screening:
Once every 12 months. Medicare also covers new digital technologies for mammogram screenings.

Pap Smear and Pelvic Examination:
(Includes a clinical breast exam) Once every 36 months. Once every 12 months if you are at high risk for cervical or vaginal cancer, or if you are of childbearing age and have had an abnormal Pap smear in the preceding 36 months. Starting July 1, 2001, Pap smear and pelvic examinations are covered once every 24 months.

Prostate Cancer Screening:

- **Digital Rectal Examination** - Once every 12 months.
- **Prostate Specific Antigen (PSA) Test** - Once every 12 months.

Shots (Vaccinations):

- **Flu Shot** - Once a year in the fall or winter.
- **Pneumococcal Pneumonia Shot** - One shot may be all you will ever need. Ask your doctor.
- **Hepatitis B Shot** - If you are at medium to high risk for hepatitis.

Glaucoma Screening:

Starting January 1, 2002, once every 12 months. Must be done or supervised by an eye doctor who is legally allowed to do this service in your state.

You Stay Healthy

Who is Covered	What You Pay
Certain people with Medicare who are at risk for losing bone mass.	20% of the Medicare-approved amount (or a set copayment amount) after the yearly Part B deductible.
All people with Medicare age 50 and older. However, there is no minimum age for having a colonoscopy.	Nothing for the fecal occult blood test. For all other tests, 20% of the Medicare-approved amount after the yearly Part B deductible. For flexible sigmoidoscopy or colonoscopy, you pay 25% of the Medicare-approved amount if the test is done in an ambulatory surgical center or hospital outpatient department.
• All people with Medicare who have diabetes (insulin users and non-users). • If requested by your doctor or other provider and you are at risk for complications from diabetes.	• 20% of the Medicare-approved amount after the yearly Part B deductible. • 20% of the Medicare-approved amount after the yearly Part B deductible.
All women with Medicare age 40 and older. You can also get one baseline mammogram between ages 35 and 39.	20% of the Medicare-approved amount with no Part B deductible.
All women with Medicare.	Nothing for the Pap smear lab test. For Pap smear collection and pelvic and breast exams, 20% of the Medicare-approved amount (or a set copayment amount) with no Part B deductible.
All men with Medicare age 50 and older.	Generally, 20% of the Medicare-approved amount for the digital rectal exam after the yearly Part B deductible. No coinsurance and no Part B deductible for the PSA Test.
All people with Medicare.	Nothing for flu and pneumococcal pneumonia shots if the health care provider accepts assignment. For Hepatitis B shots, 20% of the Medicare-approved amount (or set copayment amount) after the yearly Part B deductible.
People at high risk for glaucoma, including people with diabetes or a history of glaucoma.	20% of the Medicare-approved amount after the yearly Part B deductible.

PART I

HMO/MEDIGAP

2001 Medicare Part A Benefits and Gaps Paid by Beneficiary or Their Insurance (Refer to Medicare Handbook for complete list of Medicare benefits.)

Coverage	Beneficiary Pays	Medicare Pays
Medicare Part A		
Inpatient Hospital Care*		
Days 1-60	$792 deductible	Balance
Days 61-90	$198 per day	Balance
Days 91-150 (*lifetime reserve days*)	$396 per day	Balance
All additional days	All costs	Nothing
Semiprivate room and board, general nursing, and other hospital services and supplies.		
Skilled Nursing Facility Care*		
Days 1-20	Nothing	All costs
Days 21-100	$99.00 per day	Balance
All additional days	All costs	Nothing
After three-day hospitalization and admitted to a skilled nursing facility approved by Medicare within 30 days of discharge.		
Home Health Care**	Nothing	80% of approved amount
Part-time or intermittent skilled care, home health aide services, and		
Durable Medical Equipment and Supplies	20% of approved amount	
Hospice Care	Small co-payments for inpatient respite and drugs	Balance
Pain relief, symptom management and support services for the terminally ill.		
Blood	For first 3 pints	All but first 3 pints per calendar year

* A benefit period provides 90 days of hospital care, if needed. A new benefit period begins each time the beneficiary is out of the hospital or has not received skilled nursing care from any other facility for 60 consecutive days.

Premiums: If you are over age 65 and are eligible for a Social Security pension, then Part A is premium free. If you are not eligible, you may be able to purchase Medicare Part A or Part B, or both, by paying a monthly premium; contact a Social Security office for more information.

Medicare Part B Benefits and Gaps

(Chart outlines gaps in Medicare coverage. Refer to Medicare Handbook for complete list of Medicare benefits.)

Coverage	Beneficiary Pays	Medicare Pays
Medicare Part B		
Medical Expenses • Doctors' services • Inpatient and outpatient medical services and supplies • Physical and speech therapy • Diagnostic tests • Ambulance services. Medicare also pays for other medically necessary services, see Medicare Handbook.	$100 deductible* plus 20% of Medicare's approved amount. Limited charges above the approved amount may apply for some Part B providers.	80% of Medicare's approved amount after $100 deductible has been met. Reduced to 50% for most outpatient **mental health** services.
Clinical Lab Tests Blood tests, urinalysis, and more.	Nothing for tests if medically necessary.	Generally 100% of approved amount.
Home Health Care** Part-time or intermittent skilled care, home health aide services, and **Durable Medical Equipment and Supplies**	Nothing 20% of approved amount and excess fees charged above Medicare allowed amount	 80% of approved amount
Outpatient Hospital Treatment	After $100 deductible, 20% of the **hospital charges** (not limited to approved amount).	Medicare payment to hospital based on hospital cost.
Blood	For first 3 pints, plus 20% of approved amount (after $100 deductible).	80% of approved amount (after $100 deductible and starting with the 4th pint).

* Once you have incurred $100 of expenses for Medicare-covered services in any year, the Part B deductible does not apply to any further covered services you receive for the rest of the year. A 20% coinsurance amount applies to most physician services. A 50% coinsurance applies to most out-patient mental health services.

** If you have both Medicare Part A and Part B, your Part A will pay for home health.

Services not covered by Medicare: Private Duty Nursing, Experimental Procedures, Care Outside of the U.S., Custodial Care at Home, Custodial Care in Nursing Home, Most Prescription Drugs, Hearing Aids, Eyeglasses (generally), Most Chiropractic Services, Dental Care, Acupuncture, Routine Physicals, Private Hospital Room, Cosmetic Surgery, TV and phone in hospital.

Three Standard Medigap Plans and HMO Coverage Sold in Massachusetts – 2001

(An X indicates a covered service)

Comparison of Plans	Core	Supplement 1	Supplement 2	HMO
Basic Benefits Included In All Plans:				
Hospitalization Part A Co-payments				
Days 61 - 90: $198 per day	X	X	X	X
Days 91-150: $396 per day	X	X	X	
365 Additional Lifetime Hospital days - Paid in full	X	X	X	X
Part B Coinsurance -				
Coverage of coinsurance, in most cases, 20% of approved amount	X	X	X	X
Parts A and B Blood First 3 pints	X	X	X	X
Additional Benefits	**Core**	**Supplement 1**	**Supplement 2**	**HMO**
Part A Deductible for Hospital Days 1 - 60 $792 per benefit period		X	X	X
Skilled Nursing Facility Coinsurance Days 21-100 - $99.00 per day		X	X	X
Part B Annual Deductible - $100.00		X	X	X
Foreign Travel - For Medicare-covered services needed while traveling abroad.		X	X	X Emergency care only
Outpatient Prescription Drugs ** From Retail Pharmacies after a you meet a $35 calendar quarter deductible: • 100% coverage for generic drugs • 80% coverage for brand-name drugs			X	X Limited prescription drug coverage

** These drugs include: insulin needles and syringes provided by a home infusion therapy provider; and drugs used on an off-label basis for the treatment of cancer or HIV/AIDS and medically necessary services associated with the administration of such drugs.

HMOs may offer additional benefits e.g. dental, hearing aides, eyeglasses. Check plan's Ou tline of Coverage for additional benefits.

Medicare Supplement Plans Offered in Massachusetts

Medigap Carriers **Please note that rates may change in 2001**	Monthly Premiums for Policies Medicare Supplement Core	Medicare Supplement 1	Medicare Supplement 2
Allianz Life Insurance Company of N.A. Only for members of Air Force Sergeants Assn **1-800-882-5541** Only for members of Fleet Reserve Assn **1-800-424-1120** Only for members of Marine Corps Assn **1-800-424-5181** Only for members of Nat Assn of Retired Fed Emp **1-800-233-5764** Only for members of National Rifle Assn **1-877-672-3006** Only for members of Reserve Officers Assn of USA **1-800-247-7988** **(open enrollment: Feb-Mar; at initial eligibility)**	$62.83	$119.00	$268.67
Blue Cross & Blue Shield of MA (Medex) **1-800-258-2226** **(open enrollment: Feb-Mar; at initial eligibility[1])**	$65.58	$121.95	$345.73
Hartford Life Insurance Company Only for members of The Retired Officers Assn **1-800-247-2192** **(open enrollment: continuous)**	$44.90	$102.35	$286.26
Lincoln National Life Insurance Company Only for members of Military Benefit Assn **1-800-336-0100** **(open enrollment: continuous)**	$53.09	$78.19	$116.30
United HealthCare Insurance Company Only for members of Amer Assn of Retired Persons **1-800-523-5800** **(open enrollment: Feb-Mar[2]; at initial eligibility[1]**	$86.25	$128.75	$345.50

1. Plan offers discounted rates to certain members joining when initially eligible.
2. Plan adds surcharge for enrollment after initial eligibility period.

Medicare HMO Plans Offered in Massachusetts
For Coverage in 2002 (for coverage taking effect on January 1st, 2002)

The premium and co-payment levels printed in this chart have been submitted to the Center for Medicare and Medicaid Services, the agency that administers Medicare, on September 17, 2001. Please note the Center for Medicare and Medicaid Services must review the health plan's request and issue a final approval before November 1, 2001. These HMO plan premiums, offered under a contract with the federal government, must also be reviewed by the Massachusetts Division of Insurance. Contact the company for more information about these products.

Medicare HMO	**Monthly Premium**	**Office Copay**	**Prescription Drug Benefit Features**	**Service Area by County**
Fallon Community Health Plan, Inc. **1-800-868-5200** **TTY: 877-608-7677** **Continuous enrollment through 12/31/01; limited times for enrollment in 2002 and after. See Bulletin for details.**	Fallon Senior Plan $0	$10	$0 premium Fallon Senior Plan offers no drug benefit. **Purchase of optional supplemental drug benefit is available at an additional $45 monthly charge.** $175 per calendar quarter benefit at discounted price ($700 total per year) Co-payment (up to 30-day): $ 8 Tier I $ 15 Tier II $ 35 Tier III Mail Order (up to 30-days): Deduct $2 off the tiered co-payment levels.	Worcester County; Portions of Hampden, Hampshire, and Norfolk
	Fallon Senior Plan $10	$10	$10 premium Fallon Senior Plan offers no drug benefit. **Purchase of optional supplemental drug benefit is available at an additional $60 monthly charge.** $175 per calendar quarter at discounted price ($700 total per year) Co-payment (up to 30-day): $ 8 Tier I $ 15 Tier II $35 or 50% co-insurance Tier III (whichever is greater) Mail Order (up to 30-days): Deduct $2 off the tiered co-payment levels	Portions of Franklin and Middlesex

Medicare HMO Plans Offered in Massachusetts
For Coverage in 2002 (for coverage taking effect on January 1st, 2002)
(continued)

Medicare HMO	Monthly Premium	Office Copay	Prescription Drug Benefit	Service Area by County
Harvard Pilgrim Health Care, Inc. **1-800-779-7723** **TTY: 1-800-439-2370** **Continuous enrollment through 12/01; limited times for enrollment in 2002 and after. See Bulletin for details.**	First Seniority $60	$5	$150 per calendar quarter at retail price ($600 total per year) Copayments (30-day): $ 5 for Generic $10 for Preferred Brand $25 for Non-preferred Mail Order (90-day): $ 8 for Generic $15 for Preferred Brand $75 for Non-preferred	Essex, Middlesex Norfolk, Suffolk $60
Blue Care 65 **Blue Cross Blue Shield** **1-800-678-2265** **TTY: 1-800-522-1254** **Continuous enrollment through 12/01; limited times for enrollment in 2002 and after. See Bulletin for details.**	Blue Care 65 $110 to $135 See Service Area by County	Prim Care Physician $5 Specialist $15	$150 per calendar quarter at discounted price ($600 total per year) Retail Copay (34-day): $ 8 for Generic $15 for Brand Mail Order (90-day): $10 for Generic $20 for Brand	Middlesex, Norfolk, Suffolk $110 Franklin, Hampshire, Hampden $115 Essex, Plymouth $130 Barnstable, Bristol, Worcester $135
Tufts Associated Health Plan **1-800-246-2400** **TTY: 1-888-899-8977** **Continuous enrollment through 12/01; limited times for enrollment in 2002 and after. See Bulletin for details.**	Secure Horizons $70 to $107 See Service Area by County	$5	$150 per calendar quarter at negotiated price ($600 total per year) Retail Copay (30-day): $ 8 for Generic $15 for Preferred Brand $35 for Non-preferred Mail Order (90-day): $16 for Generic $30 for Preferred Brand $70 for Non-preferred	Suffolk, Norfolk, Middlesex, Barnstable, Plymouth, Bristol $80 Worcester, Hampden $70 Essex $107

Please Note: The premium and co-payment levels printed in this chart have been submitted to the Center for Medicare and Medicaid Services, the agency that administers Medicare, on September 17, 2001. Please note the Center for Medicare and Medicaid Services must review the health plan's request and issue a final approval before November 1, 2001.

SHINE Counseling Program **As of 10/11/01**
1-800-AGE-INFO (1-800-243-4636) (TTY: 1-800-872-0166)
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The Commonwealth of Massachusetts
Executive Office of Elder Affairs
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Massachusetts Bulletin for People with Medicare

Medicare beneficiaries have several options for receiving health care. Major health care options include:

- Original Medicare Plan (Parts A and B)
- The Original Medicare Plan plus Medicare Supplement Insurance (Medigap)
- Medicare Health Maintenance Organizations (HMOs)
- Group health coverage (coverage from your employer or spouse's employer)
- Retiree group health coverage
- Veterans' Health Care program
- MassHealth programs that pay for some or all of Medicare's deductibles, co-payments, premiums and provide additional benefits for eligible adults
- Free Care in hospitals or reduced fee care at neighborhood community health centers
- Prescription Advantage, Massachusetts' prescription insurance plan for seniors and adults with disabilities.

This Bulletin provides basic information regarding Medicare Supplement Insurance (Medigap), Medicare HMOs, MassHealth and options for acquiring prescription drug benefits. If you have employee group health coverage or retiree group health coverage, contact your employer or group insurer for information about your health plan.
If you are a veteran, contact your local veteran's agent with questions about veterans' health care services.

Included in this Bulletin are:

- Charts showing Medicare A and B benefits, co-payments and deductibles
- Charts detailing the three standard Massachusetts Medigap policies, carriers, premiums
- Charts listing Medicare HMOs with benefits, premiums and coinsurance amounts.
- Fact Sheet 4: Programs That Help You Buy Prescription Drugs

SHINE Counseling Program of the Executive Office of Elder Affairs
October 2001

The Original Medicare Plan

The Original Medicare Plan (also known as fee-for-service) has two parts. Part A helps pay for hospital stays, skilled nursing care, home health care, hospice care and other services. Part B helps pay for doctors' services, outpatient care and other medical services. Under Original Medicare, you may go to any doctor, specialist, or hospital that accepts Medicare. See the attached chart *Medicare Part A and Part B Benefits and Gaps;* also, refer to the *Medicare & You Handbook* for details. Call Medicare with questions or to order free Medicare publications listed in the handbook at 1-800-MEDICARE (1-800-633-4227)(TTY: 1-877-486-2048).

Additional Insurance
If you are in the Original Medicare Plan, you may want to consider buying a Medicare Supplemental Insurance Policy to help pay Medicare's co-payments amounts, deductibles and other out-of-pocket expenses.

As a Medicare beneficiary you can choose to receive your Medicare benefits through the Original Medicare plan and supplement it with a Medigap policy or through a Medicare Managed Care plan such as a Health Maintenance Organization (HMO). Keep in mind, no one plan is right for everyone. All plans have benefits and limitations that must be evaluated relative to your needs and personal preferences.

Medicare Supplement Insurance (Medigap Insurance)

Medicare Supplement Insurance, also known as ***Medigap*** insurance, is a policy sold by private insurance companies to fill the "gaps" in the Original Medicare Plan. When you buy a Medigap policy, you must have both Medicare Parts A & B. You must pay insurance premiums for your Medigap coverage.

Medigap policies must be clearly marked "Medicare Supplement Insurance." The three standard ***Medigap*** plans that can be sold in Massachusetts are:

- Medicare Supplement Core
- Medicare Supplement 1 (no outpatient prescription drug coverage)
- Medicare Supplement 2 (unlimited outpatient prescription drug coverage)

See the attached chart *Three Standard Medigap Plans Offered in Massachusetts* to compare the basic benefits of each plan. See the *Medicare Supplement Plans Offered in Massachusetts* chart for companies approved by the Massachusetts Division of Insurance for sale to Massachusetts residents and their current monthly premiums.

All companies must use consistant labeling of their plans and provide identical Medicare Supplement coverage. For example, Medicare Supplement 1 coverage from company LMN must be the same as Medicare Supplement coverage from company PQR. This makes comparing plans simpler.

An insurer is not permitted to sell a duplicate Medicare Supplement policy to an individual who already has a privately purchased Medicare Supplement policy. But, it is permissible for an insurer to sell a Medigap policy to someone who has an employer sponsored retiree plan. If you choose to replace a current Medigap policy, you must sign a statement indicating you are replacing a Medigap policy and will not maintain both policies.

Who Can Buy Medigap Insurance?

Medigap companies in Massachusetts cannot deny coverage, limit coverage or impose a waiting period based on pre-existing health conditions to any person, except to individuals *under age 65* who are eligible for Medicare solely due to End-Stage Renal Disease (permanent kidney failure with dialysis or a transplant). Medigap companies do not have to sell to individuals with End Stage Renal Disease until they reach the age of 65.

When Can You Buy Medigap Insurance?

You can buy a Medigap policy sold by an insurer in Massachusetts providing the insurer receives the application during a designated **Medigap Open Enrollment Period.**

a. The ***2-month annual Medigap open enrollment period*** for Medigap policies starts **February 1st and ends March 31st**. Benefits for people who enroll during the annual open enrollment period begin **June 1st.**

b. A ***six month open enrollment period*** occurs when a person:
   - enrolls in Medicare Part B for the first time, or
   - becomes a resident of Massachusetts, or
   - moves out of the service area of their HMO plan, or
   - lost or is about to lose employer coverage, or
   - turns 65, after they already became eligible for Medicare Part B benefits due to end stage renal disease *before* turning age 65.

c. A ***five month open enrollment period*** occurs if a person is:
   - enrolled in a Medicare HMO or Pace Program that announces it will stop doing business in their area as of December 31st. If this happens, the Medigap open enrollment period would begin upon the receipt of an October 2nd notification letter from the plan and end March 4 of the following year.

d. A ***63 day Medigap open enrollment period*** begins after several events, including when a person:
   - had employer health insurance coverage that pays second to Medicare, but the coverage was or is about to be stopped, or
   - loses retiree health insurance coverage, or
   - has a Medigap policy end due to an involuntary termination, or
   - is insured by a Medigap policy or Medicare HMO and the company or its agent misrepresents the policy's terms and conditions during marketing or substantially violates a provision of its policy or contract; or
   - who is enrolled in their first Medicare HMO plan decides to disenroll (for any reason) from the plan within the first 12 months of enrollment.
     i. If they had cancelled a Medigap policy to join the HMO, they can get the old policy back <u>if</u> it is still offered for sale; if not, they can choose a Core or Supplement 1 policy.
     ii. If the Medicare HMO was their <u>first choice</u> of insurance as a Medicare beneficiary, then they may select any Medigap policy offered for sale in the state.
     iii. In fact, the consumer can apply to a Medigap company up to 60 days before the actual HMO disenrollment date, so as to avoid any break in coverage;

e. In addition, there may be other events that trigger a right to buy Medigap insurance at other times of your life.

Is Your Medigap Policy Too Costly?

If you now have a Medigap policy and the premium is becoming too costly, be aware that you may:

- contact your Medigap company to see if it will let you *downgrade* your policy at this time to a lower cost policy sold by the company; most insurance companies decide to limit sales of new Medigap policies to February and March with an effective date of June 1st but some do permit downgrading throughout the year.
- Take time during November, the Annual HMO Open Enrollment Period, to consider the benefits and costs of the Medicare HMOs in your area.

- contact your local MassHealth Enrollment Center or a SHINE Counselor to determine if you are qualified for Medicaid, QMB, SLMB, or QI.
- learn about your neighborhood community health center's services and fees.
- explore free and discounted health care programs available for seniors in Massachusetts.

Keep in mind that the policy you now have may no longer be approved for sale in Massachusetts. Therefore, if you cancel it and switch to another insurer, and then change your mind, you may not be able to return.

Medicare Health Plans, including HMOs

Health Maintenance Organizations (HMOs) combine the functions of health insurance and health services in one organization. HMOs offer, on a pre-paid basis, medical and preventive services through a network of designated hospitals, doctors and other providers. One type of Medicare health plan is a Medicare Health Maintenance Organization; a private fee for service plan is another type of Medicare health plan sold in other states, but not in Massachusetts. Medicare HMO premiums and benefits stay in effect for one calendar year.

How Do Medicare HMOs Work?

When you enroll in a Medicare HMO, you are signing up to receive all your Medicare services through the HMO. Medicare prepays a monthly fixed amount to the plan. In return, the HMO is required to provide all of the services you would be entitled to under Original Medicare. Additional benefits such as periodic checkups, health screenings, vision services, prescription drugs, dental visits, hearing exams, eyeglasses and/or wellness programs may also be fully or partially covered. You must continue to be enrolled in Medicare Part A and Part B and continue to pay the Part B premium while enrolled in a Medicare managed care plan.

Medicare HMO beneficiaries are required to use only the plan's network of providers and facilities. If you choose to receive services outside the plan's network, neither the plan nor Medicare will pay. You are responsible for all charges from out-of-network providers. The only exceptions are 1) for emergencies and urgently needed care while temporarily outside the plan's service area or 2) when you receive prior approval from your primary care physician or HMO to see a specific medical provider outside the HMO's network.

Do HMOs Cover Emergency Care?
All HMO plans with Medicare contracts must cover emergency care as part of the basic benefit package. HMO plans will pay if you have a medical emergency or an urgent need for care while you are temporarily out of the HMO service area. However, they will not pay for routine care, or care you could of planned in advance.

When Can You Enroll in a Medicare HMO?

You can enroll in a Medicare HMO in Massachusetts during limited **Medicare Health Plans Open Enrollment Periods.** In 1997, Congress decided that Medicare health plans should have certain times when people can change their Medicare health plan coverage. **Note**: If you have employer or union health coverage, these rules will probably not apply to you. Talk with your employer or union benefits administrator to find out when you may enroll or change your enrollment in the insurance options they sponsor.

Initial Health Plan Enrollment Period
The Initial Health Plan Enrollment Period is the ***3-month period before the month of enrollment into Medicare Part B.*** Typically, people over the age of 65 enroll into Part B when their employer group health plan is about to end. Some people about to turn age 65 decide to take Medicare on or near their 65th birthday month. (Anyone else must wait to enroll into Medicare Part B during January-March, with a start date for Part B of July 1st.)

The ***three month initial health plan enrollment period*** runs during the 3 months before Medicare Part B (Medical Insurance) begins.

Annual Medicare Health Plan Enrollment Period
The Annual Open Enrollment Period for Medicare Health Plans for 2001 will be ***November 1st – December 31st***. (The new coverage will take effect on January 1st. (For 2002 and after, the annual open enrollment period will be November 1st - 30th .) Any one may use this time period to enroll into an Medicare HMO or switch enrollment between HMOs.

Special Medicare Health Plan Enrollment Period
Sometimes, a person with Medicare may leave their HMO and join another HMO plan for one of the reasons listed below:

- They move out of the Medicare health plan's service area.
- Medicare terminates the Medicare health plan's contract.
- The Medicare health plan withdraws from the service area.

- They show that the managed care plan has denied needed medical care, provided poor care or made false statements.

When someone moves out of the HMO service area, the HMO must send a disenrollment notice letter to the individual within 90 days after the move. The individual has ***63 days after getting their disenrollment notice*** to select another HMO plan in their new community. (A Medigap open enrollment period is also triggered when someone moves out of their HMO service area). For all other events (listed immediately above), a Medicare beneficiary has ***63 days after the event*** to select another HMO.

Rules For Switching Enrollment For Medicare HMO Members

- During 2001, Medicare HMO Plans in Massachusetts will enroll new applicants continuously throughout the year. Continuous open enrollment will end in 2002 and be replaced with one annual open enrollment period in November 2002.
- Starting January 2002, HMO members can switch enrollment (to another Medicare HMO or disenroll back to traditional Medicare) only one time between January 1st to June 30th, 2002.
- Starting January, 2003 and continuing thereafter, HMO members will be allowed to switch enrollment to another Medicare HMO or disenroll back to traditional Medicare only one time between January 1st to March 31st.

Example: Ms. Adams is currently a member of a Medicare HMO. From January through June 2002, Ms. Adams can change her choice of health plans within Medicare system **JUST ONE TIME.**

- If she wants to enroll into another HMO, she must switch directly into it by filling out the new HMO's enrollment form. She should not cancel her membership in her current HMO; Medicare will do that for her automatically once the new coverage begins.
- Or, if she wants to go back to original Medicare she must leave the current HMO by filling out a written disenrollment form. Once she has elected to return to original Medicare and leave the HMO, she cannot make another election to join another HMO; she must wait until the annual November health plan enrollment period.

NOTE: Different rules apply for Medicare HMO members who have been enrolled in Medicare for less than 6 months ("initially eligible beneficiaries") .

- Throughout 2002 you may make one switch to another health plan or return to original Medicare during the first *six* months you are a Medicare beneficiary or until December 31st , whichever comes first.
- In 2003 and any year after, you may make one change in HMO enrollment during the first *three* months you are a Medicare beneficiary or until December 31st, whichever comes first.

If you are enrolled in a Medicare health plan and your doctor, hospital or other health care provider leaves the plan during the year, ask your health plan for the names of other participating providers in your area so you can switch to a new doctor or facility.

Who Can Enroll in a Medicare Health Plan?

- You must be enrolled in both Part A (Hospital Insurance) and Part B (Medical Insurance) of Medicare.
- You must live in the HMO's service area. In general, if you move out of the plan's service area you cannot stay in the plan. You must disenroll; then, you may join another Medicare managed plan in the new area or revert to the Original Medicare Plan and purchase a Medigap policy.
- Medicare managed care plans cannot exclude anyone or limit coverage for any applicant due to poor health or current health care condition except individuals who have End Stage Renal Disease. However, if you are already in a HMO plan and have End Stage Renal Disease, you may be able to convert to your HMO's Medicare contract if they operate one. Check with your HMO to see if they have a Medicare contract.

To learn more or get an application, contact the HMOs serving your county or town and request an enrollment packet including a benefits booklet and a provider directory.

MassHealth Programs That Help Pay Health Care Costs

Several Massachusetts health insurance programs can help pay health care costs for low income Medicare beneficiaries.

MassHealth Standard Health Insurance
MassHealth Standard Health Insurance pays all of Medicare's premiums, deductibles, co-payments and provides additional benefits, including prescription drugs, dentistry, hearing aids, eyeglasses and other services. You may enroll into MassHealth if you are:

- single and your income is $736 or less per month and your assets are $2,000 or less; or
- married and your combined income is $988 or less per month and your assets are $3,000 or less. (Different asset and income rules are used when a married person needs Medicaid for nursing home care.)

Qualified Medicare Beneficiary Program (QMB)
QMB pays the Medicare Part B monthly premium as well as all Medicare deductibles and coinsurance. For example, QMB pays the Part A hospital deductible, the Part B $100 annual deductible, and the 20% co-payments for Part B services. You can enroll in QMB if you are:

- single and your income is $736 or less per month and your assets are $4,000 or less; or
- married and your combined income is $988 or less per month and your combined assets are $6,000 or less.

Specified Low-Income Medicare Beneficiary Program (SLMB) and **Qualifying Individual (QI-1) Programs**
The SLMB and the QI-1 Programs are both programs that will pay for your monthly Medicare Part B premium. You can enroll if you are:

- single and your income is $987 or less per month and your assets are $4,000 or less; or
- married and your combined income is $1,327 or less per month and your combined assets are $6,000 or less.

Call the **MassHealth Enrollment Center at 1-888-665-9993 (TTY: 800-596-1272**) for information about MassHealth Standard Health Insurance and the Medicare Savings Programs described above.

Other Programs That Can Help Pay Health Care Costs

1. **Prescription Advantage** is an insurance plan sponsored by the Commonwealth of Massachusetts that began on April 1, 2001. Prescription Advantage provides an unlimited drug benefit, including coverage for insulin and disposable insulin syringes and needles. To be eligible for the plan, you must be a Massachusetts resident who is not a MassHealth or CommonHealth member (Medicaid) and if you:

   - Are 65 years of age or older; **or**
   - Are under age 65, have a disability, have a gross annual household income not more than $16,152 (individual) or $21,828 (two person household) and either do not work, or work 40 hours or less per month; **or**
   - Were enrolled in the PHARMACY Program or PHARMACY Program Plus as of March 31, 2001. (Enrollees of these two programs must fill out a new enrollment form to participate in Prescription Advantage)

All Prescription Advantage enrollees pay a monthly premium, yearly deductible and prescription co-payments based upon annual household income. However, the Commonwealth of Massachusetts pays the premiums and deductibles for individuals and married couples with household incomes less than $16,152 (individual) or $21,828 (married couple).

- The monthly premiums for the first year range between $15 and $82 per month.
- A member's deductible for the first year will range between $100 and $500
- Stop-Loss Protection – Yearly maximum out-of-pocket costs paid by each enrollee for deductible and prescription co-payments is the lesser of either $2,000 or 10% of the member's annual gross household income, whichever is less.

You may enroll anytime within the first year without any premium penalty. Thereafter, limited periods of enrollment may be established. For information and an enrollment form call **1-800-AGE-INFO (1-800-243-4636) (TTY: 1-877-610-0241** for the hearing and speech impaired).

2. **The MassHealth Program**: MassHealth offers several insurance plans for long term unemployed adults and disabled working adults under age 65 in addition to the programs described in this Bulletin. Call the **MassHealth Enrollment Center at 1-888-665-9993 (TTY:800-596-1272)** for more information and applications.

3. **Free Care from Hospitals and Community Health Centers:** Hospitals and neighborhood community health centers provide free care or low-cost care to uninsured

or underinsured Massachusetts residents, including Medicare beneficiaries. For more information, contact your local hospital's billing office, community health center or the the **Division of Health Care Finance and Policy** at **617-988-3100.**

4. Veterans Affairs Healthcare System: To receive medical care at any VA health care facility, veterans may enroll at any time through any VA medical center or Veterans Agent office in Massachusetts. Application forms may also be obtained by calling the **VA Health Benefits Service Center 1-877-222-VETS (8387)** or visiting the VA website at **www.va.gov/health/elig** . Your local Veteran's Agent will also have information about other valuable assistance programs available to Massachusetts veterans.

5. MassMedLine: The MassMedLine helps people of all ages apply for free prescription assistance programs offered by many drug companies. The MassMedLine staff will prepare the applications, contact the individual's physician, and follow up with the individual to assure that these drugs are used correctly. **Call MassMedLine at 1-866-633-1617 (TTY: Call Mass Relay at 711).**

Help Directory

1. If you have a problem concerning your insurance or with buying insurance, or you believe that an agent, broker or company has treated you unfairly, call the **Division of Insurance, Consumer Services, 1-617-521-7777 (TTY: 617-521-7490). The Springfield area phone number is 1-413-785-5526.** The Division of Insurance web site is **www.state.ma.us/doi.**

2. For information about Medicare, local Medicare HMOs and to order free Medicare publications including the *Medicare and You Handbook* call **Medicare Hotline 1-800-638-6833 (TTY: 1-800-820-1200)** or visit the Medicare web site at www.medicare.gov.

3. Call **Medicare Part A: 1-888-896-4997 (TTY: 1-800-559-0443)** for information about Medicare A claims and benefits.

4. Call **Medicare Part B: 1-800-882-1228 (TTY: 1-800-559-0443)** for information about Medicare B claims and benefits. (For durable medical equipment only, call 1-800-842-2052.)

5. For free legal advice and help with a Medicare appeal, contact the **Massachusetts Medicare Advocacy Project at 1-800-323-3205 (TTY: 617-371-1228).**

6. Call the **MassHealth Enrollment Center at 1-888-665-9993 (TTY: 800-596-1272)** for information about MassHealth Health Insurance programs and Medicare Savings Programs.

7. Call the **Social Security Administration at 1-800-772-1213 (TTY: 1-800-325-0778)** to enroll in Medicare, replace a lost Medicare card, report a change in address or for more information about Social Security benefits including Supplemental Security Income (SSI) and Social Security Disability Income (SSDI).

8. For appealing medical decisions and filing complaints of the quality of care given to a Medicare beneficiary, call the **Mass Peer Review Organization (MassPRO) Information Line at 1-800-252-5533.**

The Serving the Health Information Needs of Elders (SHINE) Program

What is a SHINE Counselor?

A SHINE Counselor is a committed volunteer who is trained and certified by the Executive Office of Elder Affairs to explain many areas of health insurance, including Medicare, Medigap insurance, Medicare HMOs, retiree insurance plans, MassHealth (Medicaid), prescription drug benefits and options, Medicare's Savings programs (QMB, SLMB and QI)), and many other free or reduced cost health care programs.

A SHINE Counselor helps Medicare beneficiaries of all ages compare various insurance options and benefits. A SHINE Counselor can explain how Medicare works with other insurance such as Medigap and Health Maintenance Organizations, review your current coverage, provide a comparisons of plans, start an appeal, and protect individuals from paying for bills they should not pay. A SHINE Counselor can help individuals fill out insurance claims forms and public benefits applications, too.

For free and unbiased health insurance information, counseling and assistance contact the SHINE (Serving the Health Information Needs of Elders) Program at **1-800-AGE-INFO (1-800-243-4636) (TTY: 1-800-872-0166).** You may also gather health benefits and other resource information by visiting www.800ageinfo.com.

We encourage you to contact your local Council on Aging to schedule a meeting in person with a **SHINE** Counselor.

SHINE Counseling Program of the Executive Office of Elder Affairs
October 2001

A Massachusetts Guide to Health Insurance CHOICES

---Health Insurance Options for Medicare Beneficiaries and Senior Citizens

Commonwealth of Massachusetts
Executive Office of Elder Affairs

Jane Swift
Governor

Lillian Glickman
Secretary

April 2001 Edition

24

Disclaimer

The Executive Office of Elder Affairs does not sell, recommend, promote, or endorse any insurance product, company or agent. The information in this guide is being provided to assist consumers in making informed purchasing decisions. Every effort has been made to ensure the accuracy of this information; however, some of the information may be subject to correction. This guide will be updated periodically.

Credits

Each year, the Massachusetts Serving the Health Information Needs of Elders (SHINE) Program provides education and assistance to thousands of our state's elders, Medicare beneficiaries, and their family members. SHINE's CHOICES Booklet was developed to address the many questions elders have in dealing with their health insurance options.

SHINE, a free and confidential counseling service, is funded by the Executive Office of Elder Affairs and through grants from the United States Centers for Medicare & Medicaid Services, the Massachusetts Councils on Aging Grant, and in-kind donations from hundreds of member agencies and program sponsors.

This consumer booklet was adapted from materials produced by the New York Health Insurance Information, Counseling, and Assistance Program (HICAP) for use in pre-retirement educational programs. Publication made possible by a grant from the Centers for Medicare & Medicaid Services, which is the Federal Medicare agency.

Please note this booklet applies only to the options available to residents of Massachusetts. There are 53 health insurance counseling programs throughout the United States and territories. There is a listing of all the health insurance counseling programs in the *Medicare & You Handbook* or you may call 1-800-MEDICARE and ask for the contact number for the state health insurance counseling program in your state.

To locate a Massachusetts SHINE Health Insurance Counselor please call:

1-800-AGE-INFO (1-800-243-4636)
TTY 1-800-872-0166

A Massachusetts Guide To Health Insurance CHOICES -- Health Insurance Options For Medicare Beneficiaries And Senior Citizens

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INTRODUCTION

Health insurance costs are rising. Don't overlook any of the possibilities. You may find you can reduce some of your health care costs. It's your choice!

This Massachusetts-specific educational booklet was designed by the Executive Office of Elder Affairs' health insurance counseling program, Serving the Health Information Needs of Elders (SHINE), to give you an overview of the health insurance choices available once you are eligible for Medicare. Like pieces of a puzzle, there are many types of health insurance alternatives that are designed to fill the "gaps" in Medicare coverage. Choosing too many pieces - too many different kinds of coverage - is wasteful and unnecessarily expensive.

Use this booklet to explore your choices and determine which combinations will add up to affordable, adequate coverage. Then, consider meeting with a trained and certified health insurance counselor of the SHINE Program to discuss any questions you may have.

SHINE is a **free statewide health insurance counseling** program for seniors and Medicare beneficiaries in Massachusetts. It's called the **Serving the Health Information Needs of Elders - or SHINE - Program**. We strongly urge you to meet with a SHINE Counselor who can help you review your current insurance benefits and to explore other options for buying prescription drug coverage. SHINE Counselors work all across the state at Councils on Aging and senior centers in every town. For over 10 years SHINE Counselors have provided unbiased and accurate information and counseling on health insurance options for Medicare beneficiaries. **Call 1-800-882-2003 to connect with your local SHINE Counseling Program. (TTY: 800-872-0166) (Out of State: 617-727-7750).** SHINE Counselors can help you explore your health insurance options. So, call your regional SHINE Health Insurance Counseling Program today.

INSURANCE COVERAGE FOR MEDICARE BENEFICIARIES

MEDICARE

GROUP PLAN FOR ACTIVE EMPLOYEES

RETIREE PLANS **COBRA** **MEDICAID, QMB, SLMB**

MEDIGAP (MEDICARE SUPPLEMENT INSURANCE)

MEDICARE MANAGED CARE PLANS (HMO)

LONG-TERM CARE INSURANCE OR OTHER HEALTH INSURANCE

Medicare

Medicare! I have complete health care coverage!
Once you are retired and reach 65, you probably will have Medicare, a basic piece of health insurance. Medicare is the payer of health care costs for most older Americans and for some disabled Americans of any age. It is divided into two parts: Hospital Insurance (Part A) and optional Medical Insurance (Part B).

Do you need Medicare coverage?
Absolutely! Either at age 65, if you are retired, or later, if you or your spouse work and have a qualified Employer Group Health Plan (EGHP).

Who is eligible for Medicare?
You are eligible for Medicare if you or your spouse worked for at least 10 years, and you are 65 years old and a citizen or permanent resident of the United States. You might also qualify for coverage if you are a younger person with a disability or with ESRD which stands for end stage renal (kidney) disease . Most people receive Part A Hospital Insurance premium-free. If you decide you want Part B Medical Insurance, the monthly premium is $50.00 for the year 2001.

MEDICARE GAPS: Deductibles, Coinsurance, Excess Charges, or Non-Covered Services & Supplies

But will Medicare be all you need?
Probably not. Medicare was not designed to pay 100% of your health care bills. Instead, it's a cost-sharing program in which you and Medicare share your health care costs. The chart on the next two pages shows how Medicare Part A and Part B will pay part of your hospital and medical costs. It shows your responsibility - deductibles, coinsurance and permissible excess charges. You are responsible to pay fully for health care that is not covered by Medicare - prescription drugs and dental care, for example.

So how do you cover yourself for these "gaps" in Medicare?
You can adequately supplement Medicare, in most cases, with just one of the choices described on the following pages. Choosing too many different kinds of health insurance may be a duplication in coverage and unnecessarily expensive.

Read more about Medicare:
The booklet, "Your Medicare Handbook" may be obtained by calling the Social Security Administration at 1-800-772-1213.

2001 Medicare Part A Benefits and Gaps Paid by Beneficiary or Their Insurance (Refer to Medicare Handbook for complete list of Medicare benefits.)

Coverage	Beneficiary Pays	Medicare Pays
Medicare Part A		
Inpatient Hospital Care*		
Days 1-60	$792 deductible	Balance
Days 61-90	$198 per day	Balance
Days 91-150 (*lifetime reserve days*)	$396 per day	Balance
All additional days	All costs	Nothing
Semiprivate room and board, general nursing, and other hospital services and supplies.		
Skilled Nursing Facility Care*		
Days 1-20	Nothing	All costs
Days 21-100	$99.00 per day	Balance
All additional days	All costs	Nothing
After three-day hospitalization and admitted to a skilled nursing facility approved by Medicare within 30 days of discharge.		
Home Health Care** Part-time or intermittent skilled care, home health aide services, and	Nothing	80% of approved amount
Durable Medical Equipment and Supplies	20% of approved amount	
Hospice Care Pain relief, symptom management and support services for the terminally ill.	Small co-payments for inpatient respite and drugs	Balance
Blood	For first 3 pints	All but first 3 pints per calendar year

* A benefit period provides 90 days of hospital care, if needed. A new benefit period begins each time the beneficiary is out of the hospital or has not received skilled nursing care from any other facility for 60 consecutive days.

Premiums: If you are over age 65 and are eligible for a Social Security pension, then Part A is premium free. If you are not eligible, you may be able to purchase Medicare Part A or Part B, or both, by paying a monthly premium; contact a Social Security office for more information.

Medicare Part B Benefits and Gaps

(Chart outlines gaps in Medicare coverage. Refer to Medicare Handbook for complete list of Medicare benefits.)

Coverage	Beneficiary Pays	Medicare Pays
Medicare Part B		
Medical Expenses • Doctors' services • Inpatient and outpatient medical services and supplies • Physical and speech therapy • Diagnostic tests • Ambulance services Medicare also pays for other medically necessary services, see Medicare Handbook.	$100 deductible* plus 20% of Medicare's approved amount. Limited charges above the approved amount may apply for some Part B providers.	80% of Medicare's approved amount after $100 deductible has been met. Reduced to 50% for most outpatient **mental health** services.
Clinical Lab Tests Blood tests, urinalysis, and more.	Nothing for tests if medically necessary.	Generally 100% of approved amount.
Home Health Care** Part-time or intermittent skilled care, home health aide services, and **Durable Medical Equipment and Supplies**	Nothing 20% of approved amount and excess fees charged above Medicare allowed amount	 80% of approved amount
Outpatient Hospital Treatment	After $100 deductible, 20% of the **hospital charges** (not limited to approved amount).	Medicare payment to hospital based on hospital cost.
Blood	For first 3 pints, plus 20% of approved amount (after $100 deductible).	80% of approved amount (after $100 deductible and starting with the 4th pint).

* Once you have incurred $100 of expenses for Medicare-covered services in any year, the Part B deductible does not apply to any further covered services you receive for the rest of the year. A 20% coinsurance amount applies to most physician services. A 50% coinsurance applies to most out-patient mental health services.

** If you have both Medicare Part A and Part B, your Part A will pay for home health.

Services not covered by Medicare: Private Duty Nursing, Experimental Procedures, Care Outside of the U.S., Custodial Care at Home, Custodial Care in Nursing Home, Most Prescription Drugs, Hearing Aids, Eyeglasses (generally), Most Chiropractic Services, Dental Care, Acupuncture, Routine Physicals, Private Hospital Room, Cosmetic Surgery, TV and phone in hospital.

MEDICARE PREVENTIVE SERVICES

COVERED SERVICES	ELIGIBLE BENEFICIARIES	WHAT YOU PAY
SCREENING MAMMOGRAMS Once per year	All female beneficiaries age 40 and older	20% of the Medicare approved amount with no Part B deductible
PAP SMEAR AND PELVIC EXAMS Once every three years. Once per year, if you are high risk for cervical cancer or had an abnormal Pap smear in the preceding three years	All female Medicare beneficiaries	No coinsurance and no Part B deductible for the Pap smear (clinical lab charge). For doctor services and all other exams, 20% of the Medicare approved amount with no Part B deductible.
COLORECTAL CANCER SCREENING • **Fecal Occult Blood Test** Once per year • **Flexible Sigmoidoscopy** Once every four years • **Colonoscopy** Once every two years if you are high risk for colon cancer. • **Barium Enema** Doctor can substitute for sigmoidoscopy or colonoscopy.	All Medicare beneficiaries age 50 and over.	No coinsurance and no Part B deductible for the fecal occult blood test. For all others, 20% of the Medicare approved amount, after the annual Part B deductible.
DIABETES MONITORING Includes coverage for glucose monitors, test strips, lancets and diabetes training.	All Medicare beneficiaries with diabetes (insulin users and non-users).	20% of the Medicare approved amount after the Part B deductible.
PROSTATE CANCER SCREENING Digital Rectal Exam and Prostate Specific Antigen (PSA) – Once per year.	All men with Medicare age 50 and older	Generally, 20% of the Medicare approved amount after the yearly Part B deductible. No coinsurance and no Part B deductible for the PSA test.
BONE MASS MEASUREMENTS Varies with health status.	Medicare beneficiaries at risk for losing bone mass.	20% of the Medicare approved amount after the Part B deductible.
VACCINATIONS **Flu Shot** - Once per year **Pneumococcal Vaccination** ask your doctor. **Hepatitis B Vaccination**	All Medicare beneficiaries High risk beneficiaries	No coinsurance or Part B deductible for flu or pneumococcal vaccination. Hepatitis B vaccination, 20% of the Medicare approved amount after the Part B deductible.

ENROLLING IN MEDICARE

The Four Enrollment Periods: Automatic, Initial, Special, and General

"I'm retiring at 65. How do I enroll in Medicare?"
When you retire at age 65, Medicare enrollment is fairly straightforward; you are either automatically enrolled or you need to apply. When you should apply will depend upon your personal situation. The 4 enrollment periods are described below.

1. The Automatic Enrollment Period

If you are already receiving retirement benefits from Social Security or the Railroad Retirement Board when you turn 65, you should automatically get a Medicare Card in the mail about three months before your 65th birthday. This card lets you know that you have been enrolled in Medicare both Part A (Hospital) and Part B (Medical). If you do not want Part B coverage follow the instructions that come with the card. If you are under 65 and disabled, you will get a Medicare card in the mail after you have received disability benefits from Social Security (or the Railroad Retirement Board) for 24 consecutive months. Medicare coverage may begin sooner for individuals who have permanent kidney failure (End Stage Renal Disease) or need a kidney transplant.

Medicare Enrollment Periods For Those Who Do Not Receive Social Security Before Turning 65

If you are not receiving Social Security or Railroad Retirement benefits three months before you turn 65, you need to contact Social Security and apply for Medicare. To obtain the appropriate application forms for Medicare enrollment, contact any Social Security office or, if you or your spouse worked for the railroad, the Railroad Retirement Board.

When can I apply for Medicare?
You need to know you have 3 times in which you can sign up for Medicare -- you can save a lot of money, or pay big penalties, depending upon when you sign up. There are 3 enrollment periods when you can sign up:

- the Initial Enrollment Period,
- the Special Enrollment Period and
- the General Enrollment Period.

2. *Initial Enrollment Period*
You can sign up for Medicare during the initial **seven-month** enrollment period starting **three months prior** to the month of your 65th birthday and ending **three months after** the month of your 65th birthday. It is wise to apply within the three months before you turn 65. By applying early, you'll avoid a possible delay in the start of your Part B coverage.

INITIAL Enrollment Period (**Parts A or B**)

Mo. 1	Mo. 2	Mo. 3	Mo. 4 Month of 65th Birthday	Mo. 5	Mo. 6	Mo. 7

-three months prior to the month of your 65th birthday
-the month of your 65th birthday
-three months after the month of your 65th birthday

3. Special Enrollment Period for those Working After Age 65

"I'm retiring after age 65 so I will have my employer's health plan until I retire. When do I enroll in Medicare?"

One of the most important and potentially confusing issues for individuals who continue to work after age 65 is when to enroll in Medicare. Should you wait until you stop working to enroll in Medicare part A and Part B, or enroll when you turn 65?

Enrollment in Medicare Part B During the Special Enrollment Period

If you are covered by a group health plan based on your own or your spouse's **current employment** (not a plan for retired people and their spouses), you can delay enrollment in Medicare Part B (Medical) insurance without penalty. You can then enroll at retirement or termination of the employer's health plan during a **special enrollment period.**

The **eight-month** Special Enrollment Period for Medicare Part B begins the day that you (or your spouse if your coverage is based on your spouse's current employment) are no longer actively employed **OR** your coverage under the group health plan ends, **whichever comes first. Note: the group health plan must be based on current employment. It cannot be a plan for retirees.**

Enrollment in Medicare Part A During the Special Enrollment Period

Most people age 65 and over can get Medicare Part A (Hospital) **premium-free** based on their own or their spouse's Social Security record of employment. Therefore, it is to your advantage **to enroll in Part A at age 65** even if you continue to work, are covered by an employer's group health plan, and are not yet receiving Social Security pension checks.

While your employer's plan will be primary (pay first), you will then be assured of Medicare Part A benefits if they are needed. For example, if your health plan does not pay all of the cost of a hospital stay, Medicare Part A may pay all or part of the balance.

You can enroll in Medicare Part A three months before reaching age 65, or at **anytime thereafter**. Simply contact Social Security and file a special application. If you are eligible for Part A premium-free, there is no penalty for late enrollment.

SPECIAL Enrollment Period (Parts A or B)

Mo. 1 Month of Termination of Employer's Health Plan	Mo. 2	Mo. 3	Mo. 4	Mo. 5	Mo. 6	Mo. 7	Mo. 8

4. General Enrollment Period

"I'm turning 70 and do not qualify for the special enrollment period. When can I enroll in Medicare?"

The **General Enrollment Period** is for late enrollees -- those who did not enroll during the **Initial** (at age 65) or **Special** (if applicable) Enrollment Periods.

The General Enrollment Period takes place during **January, February, and March** of each year. Coverage under Medicare Part B will begin July 1 of that year.

"Is there a penalty for late enrollment?"

Yes! If you are a late enrollee and sign up for Medicare Part B during the general enrollment period, you will have to pay a permanent surcharge (penalty) of 10% of the current Part B premium for each 12 month period you delayed paying Part B premiums.

For example, if you enroll in Part B at age 70, 5 years after turning 65, the surcharge will be 50% (5 years x 10%) of the current Part B premium.

In 2001, this would mean the late enrollee would have to pay $75.00 per month for Part B, instead of $50.00 per month.

This 50% financial penalty would be added on to the monthly Part B premium for **the rest of your life!!**

"Is there any way to avoid paying this penalty? "

Yes. You may delay enrolling in Part B without penalty if you were enrolled in a group health plan based on your continuous and current employment or your working spouse's plan. You would need to enroll in Medicare during the **special eight-month enrollment period**. Other exceptions may apply particularly for disabled beneficiaries.

GENERAL Enrollment Period - January - March (for late enrollees only)

JAN	FEB	MAR	APR	MA	JUN	JUL	AUG	SEP	OCT	NOV	DEC
Open	Enroll	ment				July 1st Medicare Coverage Begins					

For more information or help with Medicare enrollment, contact Social Security at 1-800-772-1213 or TTY: 1-800-325-0778 or the Railroad Retirement Board at 1-800-808-0772.

"I'm younger than 65 and receive a Social Security Disability Insurance pension - when can I enroll in Medicare?"

You have a waiting period of 24 months after your disability pension begins before your Medicare coverage starts. For the 24 month waiting period, consider other types of insurance such as your employer's plan for active employees or continuation coverage for recently retired employees ("COBRA coverage"), a spouse's employer plan, if available, MassHealth for adults with disabilities, non-group insurance for individuals, or Prescription Advantage for drug coverage only. See other sections in this book for more details on all of these options.

"I'm younger than 65 but want to enroll in Medicare because I was just told I have ALS - also known as "Lou Gehrig's Disease" - how can I enroll?"

Contact Social Security at 1-800-772-1213 or TTY: 1-800-325-0778 and request immediate enrollment into Medicare. As of July 1, 2001, individuals diagnosed with ALS do not have to abide by the 24-month waiting period for Medicare beneficiaries with disabilities.

"I'm younger than 65 but want to enroll in Medicare because I have End Stage Renal Failure - how can I enroll?"

For more information or help with Medicare enrollment, contact Social Security at 1-800-772-1213 or TTY: 1-800-325-0778. If you need a kidney transplant or participate in a self care training prgram, your Medicare coverage will begin almost immediately. If you have started dialysis treatment, your Medicare coverage will begin after a 3 month waiting period.

CURBING MEDICARE AND MEDICAID FRAUD AND ABUSE

In 1997, the U.S. General Accounting Office estimated that a minimum of **$1** out of every **$10** spent for **Medicare** and **Medicaid** is lost to fraud and abuse. Losses consequently may result in increased Medicare premiums and/or cutbacks in health-care services.

What is Medicare or Medicaid Fraud?

Intentional deception or misrepresentation that a person knowingly makes, that could result in an improper payment or other benefit.

What is Medicare or Medicaid Abuse?

Unintentional business practices of providers that may result in inadequate services and/or incur unnecessary costs to the program.

Examples of Medicare or Medicaid Fraud or Abuse

- Billing for services, supplies or equipment that were never provided to a patient
- Incorrectly upgrading or describing services on claim forms to receive higher payment
- Through deception, getting Medicare or Medicaid to pay for unnecessary services, supplies or equipment
- Denial or unreasonable delay in receiving necessary Medicare covered services

What You Can Do To Combat Medicare or Medicaid Fraud or Abuse

- Be an informed consumer! Know your health plan benefits, patients' rights and right to appeal .
- Examine your medical bills, statements and Medicare notices for errors
  Make sure that Medicare did not pay for services, supplies or equipment that you did not receive
- Do not hesitate to contact your health care provider (doctor, hospital, supplier etc.)or Medicare carrier or intermediary if you have any questions about bills or services
- You have a right to request an itemized statement from your Medicare provider. You must receive it within 30 days of your request
- Guard your Medicare or Medicaid number - like you do with your credit card number-do not give your number over the telephone or to people you do not know
- Beware of telemarketing, TV ads, door-to-door selling, offers of "free" services or pressure tactics to get you to accept products or services
- Report suspected Medicare fraud or abuse to the regional **Medicare Fraud and Abuse Hotline 1-800-882-1228**
- Report suspected Medicaid fraud and abuse to **Medicaid Fraud Control** 617-727-2200, Ext. 3404
- Contact your local **SHINE** Counselor for assistance with billing problems and fraud and abuse complaints.

How to Report Billing Problems or Medicare or Medicaid Fraud or Abuse

If you have questions concerning Medicare coverage or charges on your medical bill, statement , Medicare Explanation of Benefits (EOMB) notice or Medicare Summary Notice (MSN) call your health care provider (doctor, hospital, nursing home, supplier etc.). If you still have questions, then call Medicare Part A Fiscal Intermediary or Medicare Part B Carrier. A third Carrier handles just Durable Medical Equipment questions.

The appropriate Medicare Part A Fiscal Intermediary or Medicare Part B Carrier telephone number also appears on your Medicare Notice.

Billing Questions:

Medicare Part A - Fiscal Intermediary
(hospital, skilled nursing, hospice, home health)
Associated Hospital Service of Maine — 888-896-4997

Medicare Part B - Carrier
(medical services)
National Heritage Insurance Co. — 800-882-1228

Medicare Part B - Carrier
(home medical equipment & supplies)
HealthNow — 800-842-2052

To Report Medicare Fraud or Abuse:

Regional Medicare Fraud Hotline — 800-882-1228

To Report Medicaid Fraud or Abuse:

Office of the Attorney General
Medicaid Fraud Control Unit — 617-727-2200 Ext. 3404

HEALTH INSURANCE CHOICES FOR MEDICARE BENEFICIARIES AND SENIOR CITIZENS

What are my current options for health care as a Medicare beneficiary?

Currently, Medicare beneficiaries have several options available to them for receiving medical coverage. These include:

- continuing coverage through the current employment of yourself or a spouse
- retiree health plans from past employers
- Medicare supplement insurance-known as Medigap
- health maintenance organizations with Medicare contracts
- Medicare Parts A and B only
- MassHealth programs that pay some or all of Medicare's deductibles, copayments and premiums
- free care from hospitals and neighborhood health plans

1. Employer Group Health Plans

"I'm over 64, but still working! What are my options?"

You may be able to obtain health insurance coverage through your current employer. If you continue to work for an employer who has 20 or more employees, the employer is required, by law, to offer you and your spouse the same choice of health care plans offered to employees under age 65.

Do I need to enroll in Medicare Part B while I am still working?

No, you may delay enrolling in Part B without penalty if the group health plan is based on your continuous and current employment. This waiver of penalty also applies if you are covered under a working spouse's plan.

Choices?

Some companies offer their employees only one health insurance option. Or, your employer may ask you to choose one of several plans you would like for the coming year. For example, the choice may be between a fee-for-service health insurance plan (indemnity) or a managed care plan such as an HMO or Preferred Provider Organization (PPO). Be aware the HMO plan offered by your employer will not have the same benefits as a Medicare-contracted HMO plan because it is a different contract for care.

Benefits?

The employer plans available to you might be more comprehensive and less costly than what you can get in a Medigap (non-group) policy or Medicare HMO. Since employment-related plans are individualized for each company or organization, there are virtually thousands of them in force, with no two alike in benefits and costs.

Use the checklist and comparison charts on page 18 and 32 to illustrate for yourself the benefits and limitations of your health plan. If you do not have a current copy of your plan's benefit booklet, contact your employer's human resource department or employee benefits coordinator.

If I decide to continue with my employer health plan and enroll in Medicare Part A only, who pays first?

If you are actively working, the employer plan will pay first on your hospital and medical bills. If the employer plan does not pay all of your expenses, Medicare may pay as a secondary payer for Part A covered services such as hospitalization, skilled nursing facility care, home health and hospice care.

2. Employer Sponsored Retiree Plans

"What are my options if I have a retiree plan and Medicare?"
Roughly 1/3 of retired Americans have this piece of the health care puzzle -- a health insurance plan from their former employer. When you become eligible for and enroll in Medicare, your retiree plan will be the secondary payer after Medicare. You will use this retiree plan to supplement Medicare, to pay some of the costs Medicare does not pay.

Value?
Your retiree plan might be more comprehensive, less costly, or both, than the coverage most elders can get in a Medigap policy or Medicare HMO plan.

Benefits?
Your retiree plan is **not** a Medigap policy, but it may pay like one. Or it may pay more -- providing additional benefits, for example. Retiree plans are all unique. Contact your employee benefits representative for a benefits booklet and learn:

- your benefits; if and how they fill (or don't fill) Medicare gaps
- your lifetime maximum benefit
- your (or your spouse's) ability to continue coverage if the retiree dies

Choices?
Each year your former employer may ask you to choose which of several plans you would like for the coming year. For example, the choice may be between a fee-for-service health insurance plan (indemnity) or an HMO. Be aware the HMO plan offered as a retirement benefit may or may not offer the same benefits as a Medicare-contracting HMO plan.

"What if my retiree plan ends, becomes too expensive, or has no worthwhile benefits?"
Many employers are changing retiree health plan benefits -- either increasing your share of the premiums, cutting benefits, increasing deductibles, or all of the above. Some have dropped retiree health coverage entirely.

Alternatives?
Enrolling in a Medigap policy or Medicare HMO plan are two options you may want to consider. If your income is low, you may qualify for Medicaid or a Medicare Buy-In Program (QMB & SLMB). In some cases, these alternatives might provide better or more appropriate benefits, be more cost-effective, or coordinate with Medicare more to your advantage. See page 33 to learn more about Medicare Buy-In and Medicaid Program rules.

Employer Health Insurance Plan Review

SOME THINGS TO CONSIDER ABOUT YOUR EMPLOYMENT RELATED BENEFIT PLAN

Does the employer's plan continue after retirement? _____

Does the plan appear to be secure, or is the employer cutting back on benefits? _____

Does the plan cover the retired person's spouse or other dependents? _____

Will the spouse/dependent be covered if the retired person dies? _____

What are the lifetime maximums in the employer's plan? _____

What are the deductibles or co-payments in the employer's plan? _____

Hospital deductible or co-payment _____

Emergency room or hospital outpatient deductible or co-payment _____

Medical deductible or co-payment _____

Other deductibles or co-payments _____

Does the employer's plan provide dental, eyeglasses, hearing or other benefits? _____

Does the plan require the use of participating or preferred providers? _____

Does the plan provide a prescription drug benefit? How does it work? _____

Is there a stop-loss or out-of-pocket limit? _____

How much does the employer's plan cost per month? _____

FOR ASSISTANCE IN UNDERSTANDING YOUR SPECIFIC BENEFITS AND THEIR COORDINATION WITH MEDICARE, CONSULT A SHINE COUNSELOR.
CALL (800) AGE-INFO (800-243-4636)
TTY: 1-800-872-0166

3. Medigap Or Managed Care?

"What are my alternatives if, after 65 I decide to retire, or my health insurance becomes too expensive?"

First, you will need to enroll in Medicare. If your employer group coverage is terminated or you stop working, whichever comes first, you will have **eight months** in which to enroll in Medicare without a penalty surcharge.

Once you have Medicare, like most people you will probably want additional health coverage that helps pay for what is not covered by Medicare. Keep in mind, no system of enhancing Medicare coverage is right for everyone. All plans have benefits and limitations that must be evaluated relative to your lifestyle and personal preferences.

As a Medicare beneficiary you can choose to receive your Medicare benefits **either** through the fee-for-service system or through a managed care plan such as a Health Maintenance Organization (HMO).

Medicare Supplements

Medicare supplemental insurance, also known as **Medigap** insurance, is designed to help fill in some of the gaps in coverage left by Medicare. A Medigap policy is an indemnity or fee-for-service policy. This means you may choose any doctor, specialist, or hospital you wish. When you buy a Medigap policy, you must have both Medicare A & B. You must pay monthly insurance premiums and may still have to pay for some Medicare deductibles and co-payments. The plans that cover the costs of prescription medications may have claims forms.

Medicare Managed Care Plans (including Medicare HMO's)

When you join a Medicare-contracting HMO, you will continue to pay the monthly Medicare Part B premium. Depending on the plan, you may also pay a monthly premium and small co-payments for office visits, prescription drugs and other services. Generally, you must receive all covered services from the doctors, hospitals, and other health care providers that are part of the HMO's network for the HMO to pay. Some exceptions include emergency care, urgent care outside the HMO service area, and care authorized by the HMO or your primary care physician.

Regardless of whether you choose fee-for-service or managed care, you retain all of your Medicare benefits, protections and appeal rights.

"Medigap" (Medicare Supplement Insurance)

"Don't all Medicare enrollees need a Medigap insurance policy?"
No! Not everyone needs a Medicare Supplement (Medigap) health insurance policy.

Who should purchase?
A privately purchased Medicare Supplement, often called a "**Medigap**" policy may be a necessary piece of health insurance:

- if you do not have a retiree plan, or if your retiree plan is extremely limited in coverage or
- if you are not eligible for Medicaid or Medicare's Buy-In Programs (QMB, SLMB).

Who can purchase?

- must be eligible for Medicare Part A & B and enrolled in Medicare Part B,
- must be a resident of Massachusetts at the time of purchase, and
- if under the age of 65, cannot have End Stage Renal Disease.

Medigap options?
There are currently three types of Medigap plans available for sale in Massachusetts from both commercial and not-for-profit companies. They are named "**Core**", "**Supplement 1**", **and** "**Supplement 2**". Companies may use additional brand names, too. These plans range in cost from $800 to $4,100 per year per individual.

There will still be medical costs that neither Medicare nor your Medigap policy will pay. But, with Medicare plus a Medigap policy, you will have protection against large out-of-pocket costs for hospital and physician bills.

Use caution when:

- **Replacing your old Medigap policy** -- All companies must use consistent labeling of their plans. This labeling is Core, Supplement 1 and Supplement 2. The benefits are virtually identical for each "type" of plan. For example, Supplement 1 offered by one company has the same coverage and benefits as Supplement 1 offered by another company. This makes comparing plans easier. It's the company's premiums and customer service that vary!
- **Canceling your current Medigap policy** -- Keep in mind, the plan you now have may no longer be approved for sale in Massachusetts. Therefore, if you cancel it and then change your mind, you may not be able to switch back.
- **Buying more than one Medigap policy** - It is illegal for an insurer to sell a duplicate Medicare Supplement policy to an individual who already has a privately purchased Medicare Supplement policy. But, it is permissible for an insurer to sell a Medigap policy to someone who has an employer-sponsored retiree plan. If you choose to replace a current Medigap policy, you must sign a statement indicating that you are replacing a Medigap policy and will not keep both policies.

Is your Medigap policy too costly?

If you now have a Medigap policy and the premium is becoming too costly, be aware that you may:

- downgrade to a lower cost plan with your current insurance company, although company may limit opportunity to downgrade to certain months of year;
- during open enrollment, switch to another company offering similar Medicare supplement insurance with a lower premium;
- compare the benefits and costs of Medicare HMOs in your area;
- contact your local Division of Medical Assistance to determine if you qualify for Medicaid, QMB, or SLMB;
- Explore other free and discounted health care programs available for seniors in Massachusetts.

Basic Facts about Massachusetts Medicare Supplement Insurance

⇒ **Simplification:** Insurers who wish to sell policies in Massachusetts must sell Core and Supplement 2, and may sell all three standard plans. Remember, you should only purchase one Medicare supplement policy.

⇒ **Coverage:** Duplicate coverage is expensive and unnecessary. Agents are prohibited from selling you a Medicare supplement policy if you already have one and you do not want to replace it.

⇒ **Pre-existing conditions:** If you meet the eligibility requirements (see page 15), an insurer selling in Massachusetts is not allowed to impose any waiting period for pre-existing conditions.

⇒ **Renewals:** All individual Medicare supplement plans sold in Massachusetts must be "**guaranteed renewable**." State law prohibits companies from canceling these policies except for non-payment of premium or for incomplete or incorrect information on your original application.

⇒ **Open Enrollment:** Federal and state laws require all companies to sell their policies during specific "**open enrollment periods**" to all who want to buy a policy. If you enroll during these enrollment periods, the company must accept your application regardless of your medical history, health status or claims experience and cannot discriminate in the pricing of the policy based upon these factors. See pages 22-23.

⇒ **Free Look Provision:** Beginning the day you receive the approved Medigap policy, you have 30 days to review it. If you change your mind, you can cancel the policy within those 30 days and get a full refund.

When can I enroll in a Medigap plan?"

Under the circumstances and open enrollment periods listed on the next 2 pages, a Medigap insurer must accept your application. They may require you live in Massachusetts and be eligible for Medicare Part A and Part B and enrolled in Medicare Part B.

Your age is:	And you are:	You can enroll in any Medigap plan approved for sale in Mass*:
Under 65	Enrolling in Medicare due to a disability other than end-stage renal disease	**Within six months** of your effective date for Medicare Part B Note, you will also have another **six months** to enroll when you turn 65 and are already on Medicare Part B
Approaching 65	Enrolling in Medicare during your initial seven-month enrollment period	Up to **three months** before the month of your 65th birthday and within ***six months*** of your effective date for Medicare Part B
Over 65	Retiring from an employer-sponsored health plan and/or enrolling in Medicare Part B	Within **six months** of your effective date for Medicare Part B
Any age and enrolled in Medicare Part B (except if you are under age 65 and on Medicare solely due to end-stage renal disease)	Losing an employer-sponsored health plan because your job ended or your employer stopped offering health coverage to employees like you	Within **six months** of loss
	or	
	Covered by an HMO but are moving out of the HMO's service area	Within **six months** of move
	or	
	Becoming a resident of Massachusetts	Within **six months** of move
	or	
	Interested in purchasing Medigap	Every **February and March** each year and coverage is effective June 1st. In addition, Medigap insurers may have open enrollment periods during other times of the year or all year long (continuous open enrollment).

See next page for additional events that give you the right to buy a Medigap policy at other times.

In addition to the times you may purchase Medigap insurance as shown in the chart on the previous page, there are certain other situations that may give you the right to buy a Medigap policy when your health coverage changes. You will have to act within the required time frames to receive these protections.

Examples of events that may apply to you:

1. You just lost a health insurance policy provided to you as a **retiree** that paid for supplemental benefits.
2. Your Medigap company either became insolvent, bankrupt, substantially violated a provision of policy or misrepresented the policy terms.
3. Your Medicare HMO violated a contract term or marketing rules.
4. Your Medicare HMO is leaving the county or local service area where you live and you stayed enrolled through its last day of business in your service area.
5. When you became eligible for Medicare B, you chose a Medicare+Choice HMO plan as your first supplement to Medicare. After less than 12 months in the HMO, you now want to disenroll and buy your first Medigap policy.
6. You are a member of a Medicare HMO still in the first 12 months of enrollment and you want to disenroll and repurchase your previously owned Medigap policy.

In the above examples 1 through 6, you have 63 calendar days to buy a Medigap policy.
In the above examples 1 through 4, you have a right to purchase a Medigap Core or Medigap Supplement # 1 type of policy.
In the above example 5, you have the right to purchase any type of Medigap policy.
In the above example 6, you have the right to buy the same previously owned Medigap policy if still available for sale. If not available, then you have a right to buy a Medigap Core or Medigap Supplement # 1 type of policy.

Please Note: In example # 4 above, you must stay in your health plan until the date your coverage ends. If you leave the plan before then, you may lose your federal right to buy a Medigap plan (unless or until there is a state open enrollment. See below).

Open enrollment to purchase Medigap policies in Massachusetts.

- As of January 2001, there is no company in Massachusetts that has continuous open enrollment for all three types of Medigap (Core, Supplement # 1 and Supplement # 2) policies.
- Medigap companies can file with the Division of Insurance to request a voluntary open enrollment. Check with the SHINE Program to see if there are other Medigap companies that have open enrollment.
- There is a Massachusetts State mandated annual Medigap open enrollment period February and March of each year; however, coverage may not be effective until June 1 of that year.

Please be sure to contact the SHINE Program if you have any question about your choices, the right time to buy a Medigap plan and what the requirements are.

Three Standard Medigap Plans Sold in Massachusetts - 2001

Comparison of Plans	Core	Supplement 1	Supplement 2
Basic Benefits Included In All Plans:			
Hospitalization Part A Co-payments			
Days 61 - 90: $198 per day	X	X	X
Days 91-150: $396 per day	X	X	X
365 Additional Lifetime Hospital days - Paid in full	X	X	X
Part B Coinsurance -			
Coverage of coinsurance, in most cases, 20% of approved amount	X	X	X
Parts A and B Blood First 3 pints	X	X	X
Additional Benefits	**Core**	**Supplement 1**	**Supplement 2**
Part A Deductible for Hospital Days 1 - 60 $792 per benefit period		X	X
Skilled Nursing Facility Coinsurance		X	X
Days 21-100 - $99.00 per day			
Part B Annual Deductible - $100.00		X	X
Foreign Travel - For Medicare-covered services needed while traveling abroad.		X	X
Inpatient Days in Mental Health Hospitals In addition to Medicare's coverage of 190 lifetime days and less any days previously covered by plan in same benefit period	60 days per calendar year	120 days per benefit period	120 days per benefit period
Outpatient Prescription Drugs ** From Retail Pharmacies after a you meet a $35 calendar quarter deductible:			
• 100% coverage for generic drugs			X
• 80% coverage for brand-name drugs			
State-Mandated Benefits: Annual Pap Smear Tests and Mammograms. Check your policy for other state-mandated benefits	X	X	X

** These drugs include: insulin needles and syringes provided by a home infusion therapy provider; and drugs used on an off-label basis for the treatment of cancer or HIV/AIDS and medically necessary services associated with the administration of such drugs.

Medicare Managed Care Plans (HMO's)

"My Medigap plan with prescription coverage is getting too expensive. But I need more coverage than Medicare alone!"

In Massachusetts, the number of Medicare beneficiaries enrolled in Medicare HMOs (health maintenance organizations) is greater than the number of consumers who purchase individual Medigap policies. Today, a managed care plan can be an affordable option to fill Medicare gaps and enhance your health coverage.

What is "Managed Care"?

Managed care combines the functions of both health insurance and health services in one organization. It offers, on a pre-paid basis, medical and preventive services through a network of designated hospitals, doctors and other providers. An HMO is a managed care plan.

How do Medicare HMOs work?

When you enroll in a Medicare HMO, you are signing up to receive all your Medicare services through the HMO. Medicare prepays a monthly fixed amount to the plan In return, the HMO is required to provide all of the services you would be entitled to under Medicare coverage. Additional benefits such as periodic checkups, health screenings, vision services, prescription drugs, dental visits, hearing exams, eyeglasses and/or wellness programs may also be covered.

HOW MEDICARE HMOs WORK

- offer a full range of Medicare-covered services plus more from a network of doctors, hospitals, nursing homes and other health care providers/facilities
- access to services coordinated by primary care physician
- low or zero ($0) premium depending on the plan
- you must continue to pay your Part B premium to Medicare
- co-payments (generally $5 to $15 per visit)
- virtually little or no paperwork
- supplemental (Medigap) policies not needed

It's wise to compare benefits and costs. Some HMO plans charge you a fixed monthly premium while others offer a "*zero premium*" plan. Small co-payments may apply when you receive certain services such as office visits. When you join an HMO plan, that plan provides the care and processes most of the paperwork internally. In most cases, there are no claim forms or confusing reimbursement schedules.

Choosing your Primary Care Physician

Some seniors shy away from HMOs because of the requirement that they use the HMO plan's staff of physicians. However, this is not necessarily a limitation because many physicians participate in HMO's as well as the fee-for-service system. Ask your primary doctor or specialists if they participate in a Medicare Managed Care Plan -- they just might!

Upon joining an HMO, you will be asked to choose a primary care physician from a list of doctors who work for or are associated with the HMO. Your doctor is responsible for coordinating all your health care. Primary care physicians provide routine medical care, refer you to specialists within the network (in most cases), and arrange for hospital admissions.

- **When you enroll, you must choose a primary care physician** from the HMO's directory or one will be assigned to you.
- **HMO plans with Medicare contracts are required to provide access to** a sufficient number of physicians to satisfy the needs of its membership. It is important to ask if the primary care physician you want is currently accepting new patients.
- **All HMO plans must allow you to switch physicians** if you are not satisfied with the care you are getting. You may pick another one from the plan's network.

Medicare Contracts with HMOs to Provide Medicare Covered Services:

Under an HMO plan there is a **"lock in provision"**, which means members are required to use the plan's network of providers and facilities only. If you receive services outside the plan's network, **neither** the plan *nor* Medicare will pay. You will be responsible for **all of the charges** for the out-of-network provider. The only exceptions are for emergencies, urgently needed care while temporarily outside the plan's service area, or when you receive prior approval from your primary care physician or HMO to see a specific medical provider outside the HMO's network.

Do HMOs cover emergency care?

All HMO plans with Medicare contracts must cover emergency care as part of the basic benefit package. HMO plans will pay if you have a medical emergency or an urgent need for care while you are temporarily out of the HMO's service area. However, they will not pay for routine care, or care you could have planned in advance.

"How do I choose an HMO?"

Look at the "**Medicare HMO Comparison Chart**" published by SHINE to learn more about which Medicare HMOs are available, their service area, and how each plan differs in premiums and co-payment costs. Information on HMOs is also posted at www.medicare.gov in the Health Plan Compare section. Then, contact the HMO at the address shown or by phone to get additional information.

Before you join, be sure to read the HMO's membership materials carefully. Learn your rights and the extent of your coverage. If you live in an area served by more than one HMO, compare benefits, costs and other features to find which best suits your needs at a price you can afford.

How do I enroll in a Medicare HMO?

The only way to enroll with the HMO is with the plan itself. You will need to complete the HMO's "**enrollment application**" and submit it to the HMO. To get an application form, call the HMO or stop by an HMO sales presentation.

"Who can enroll in a Medicare HMO?" You may enroll in a Medicare HMO if you:

- **are enrolled in at least Medicare Part B and pay the Part B premium**
- **live in the HMO's service area**
- **do not have end stage renal disease** (however, if you have ESRD but are already enrolled in an HMO through your employer health plan and the HMO also offers a Medicare HMO, you can switch into the Medicare HMO contract. Call the HMO for more information.)

When can I enroll?

In 2001, Medicare Managed Care plans in Massachusetts will enroll eligible applicants throughout the year. Starting in June 2001, enrollments must take effect on the first of the very next month after you submit your enrollment form to an HMO. Call your Medicare HMO plan to determine the effective date of health benefits coverage.

If you are about to get Medicare A and B, you **must** complete the HMO's enrollment form during the 3 months before the month Medicare begins to get HMO coverage. If you have submitted the enrollment form on time, then your HMO coverage shall begin the same month as your Medicare health insurance. If you submit them too late, then you may have to wait until the November annual open enrollment period for Medicare HMOs.

Starting each November, Medicare HMOs open enrollment for new coverage to begin on January 1st.

Beginning in 2002, Medicare beneficiaries in HMOs will only be allowed to leave an HMO or change to a new HMO or go back to traditional Medicare during the first 6 months of the year, January to June. After June, you will not be able to make a new election until January 1st. Then, in 2003 and beyond, Medicare beneficiaries in HMOs will only be allowed to change their HMO election during January to March, the first 3 months of the year. (Congress enacted these 6-month and 3-month "enrollment lock-in provisions" in 1997.)

Medicare +Choice Options

I've heard about new options called Medicare +Choice - what does it mean?
Medicare +Choice options were created by Congress as part of the Balanced Budget Act in 1997. All these new health coverage plans, in addition to current options, are called "Medicare +Choice" options because each adds onto basic Medicare benefits in some way. At this time, the only official Medicare +Choice type of plan available so far in Massachusetts are Medicare HMOs.

- **Your Original Fee-for-Service Medicare -** Under Original Medicare beneficiaries receive medical care and services from any provider who agrees to serve Medicare beneficiaries.

- **Health Maintenance Organizations (HMO) -** In Medicare HMOs, beneficiaries must obtain services from a designated network of doctors, hospitals, and other health care providers who have agreed to serve plan enrollees, usually with little or no out-of-pocket payments for services. Beneficiaries must receive services from the designated network for full coverage. HMOs do not pay for out of network services unless an emergency or urgent care situation occurs.

- **Health Maintenance Organizations with a Point of Service (POS) Option -** A Point of Service option is a benefit that the HMO plan can offer to its enrollees as an additional, mandatory, supplemental benefit. HMOs with a Point-of-Service option allow members to receive certain services outside the provider network. Members typically have higher cost-sharing requirements for services received out of network and may also be charged a premium for the POS benefit options.

- **Preferred Provider Organizations (PPO) -** Beneficiaries in a PPO can obtain services from a network of health care providers that has been set up by the health plan. Unlike an HMO, beneficiaries can choose to go to providers who are not in the network and the plan will still pay a percentage of the costs while the beneficiary is responsible for the rest.

- **Provider-Sponsored Organizations (PSOs) -** PSOs are a relatively new form of managed care that work much like an HMO, except they are formed by a group of hospitals and doctors who directly take on the financial risk of providing comprehensive health benefits for Medicare beneficiaries. Beneficiaries must obtain services from the designated network for full coverage. Out of network coverage will be limited to emergency and urgent care.

- **Private Fee-For-Service Plans (PFFS) -** with a PFFS plan the beneficiary can select any provider who agrees to abide by the PFFS fee schedule. As of May 2001, over 35 states have one PFFS option available for sale. The insurance plan, not Medicare, decides how much to reimburse for services provided. Medicare pays the plan a premium to cover traditional Medicare benefits. Providers are allowed to bill beyond what the plan pays (up to

a limit), and the beneficiary is responsible for paying whatever the plan doesn't cover. The beneficiary may also be responsible for additional premiums.

- Medical Savings Accounts (MSAs) - The MSA, the beneficiary chooses a Medicare MSA Plan (a health insurance policy with a high deductible) and opens a Medical Savings Account. Medicare pays the premium for the MSA Plan and makes a deposit into this account. The beneficiary may use the money in the MSA to pay towards some of the deductible. The beneficiary may have to pay for other services to meet a high deductible. The deductible must be paid before any services are paid by the health policy. Unlike other Medicare plans, there are no fee limits on what providers can charge above the amount paid by the Medicare MSA Plan. Unlike other Medicare+Choice options, individuals who enroll in MSAs are locked in for the entire year, with a one-time option of withdrawing by December 15th of the year in which they enrolled.

Consumer Rights For Medicare Beneficiaries Enrolled in HMOs: Appeals, Grievance Rules, and How to Disenroll

"What if I'm not happy with my Medicare HMO?"

Grievances

If you have a complaint about the **quality of care** you receive, you can follow your HMO's grievance procedure. You will find the grievance procedures outlined in the plan's member handbook. Or you can file a "**Quality of Care Complaint**" with the Massachusetts Peer Review Organization (MassPRO) by calling their Hotline at **1-800-252-5533.**

Appeals

Medicare beneficiaries can challenge medical decisions made by HMO doctors and staff and appeal for coverage for services. Essentially, a Medicare beneficiary may believe a service is medically necessary under Medicare's guidelines, while the plan believes its time to stop services because they are no longer medically necessary. If an HMO disagrees with the beneficiary and denies approval for a new service or decides to stop the continuation of a current service, then beneficiaries can request an appeal. Normally, managed care plans have 14 days to consider a Medicare beneficiary's request for a service which the plan has refused to provide.

Medicare beneficiaries also have the right to receive **a fast decision** from their HMO. This faster decision process is called "an expedited 72-hour organization determination". **An expedited 72-hour decision must be made if the beneficiary's health, life or ability to regain maximum function may be jeopardized by the standard 14-day determination process.** Beneficiaries should ask for a fast decision ("expedited decision" or "expedited organization determination") if they think:

- the HMO will not approve or give him/her medical care or services that should be covered, or
- the HMO is stopping care that he/she still needs, or
- the HMO is decreasing the amount, level or frequency of services.

The HMO will decide whether or not a 72-hour /fast decision indeed needs to be made. If a fast decision is not granted, the appeal will automatically enter into the standard 14 day process. While HMOs have the responsibility for deciding whether or not a request for a fast decision shall be granted, **if a physician makes the request on behalf of the beneficiary, or even if a physician files a statement in support of the request (the statement may be oral or in writing), then the health plan must issue a fast decision.**

How To Request A Fast, Expedited Decision

To make a request for a fast 72-hour decision, you may call the HMO and request it, drop-off a written request at an HMO's office, fax the request to the HMO's office, or mail a request to the HMO's Appeal Department. Make your request for a 72-hour decision by stating, "I want an expedited decision, fast decision, or 72-hour decision, or I believe my health should be seriously harmed by waiting 14 days for a standard decision."

- If your request is made by telephone, the plan must write down your request and start its decision process.
- You may hand-deliver your request to an HMO office site, typically their primary care physician's office and/or the HMO's headquarters office.
- You may FAX the request to the plan's Complaints & Appeals Office. If you are a patient in a hospital or skilled nursing facility, ask the facility's staff to FAX the request for you.
- You may mail a written request to the plan's Appeal Department; the 72-hour process will start as soon as they receive your request. Ask your Primary Care Physician or call your HMO to get the telephone number and address of the plan's Appeals and Complaints office.
- All plan handbooks include instructions on how to start an appeal.

If the plan agrees to perform a 72-hour decision, they must notify you of their decision to either deny or provide services before the 72 hours end. On the other hand, the plan may decide your condition does not require a fast decision. If so, the plan must notify you immediately, and send a written explanation within two working days. The plan's letter must explain that your request will be processed through the standard 14-day decision process. At this point, if you still think you need the services in dispute, then they may ask for an **expedited appeal**.

Special Rules For Appealing An Early Hospital Discharge:
If you are in the hospital, the HMO must give you written notice called a "**Notice of Non-Coverage.**" You have the right to request an immediate review by calling MassPRO at **1-800-252-5533** by noon of the next business day after the date on this Notice. While MassPRO reviews the discharge decision, you will not be responsible for the additional days stay.

"How can I disenroll from my Medicare HMO?"
You may cancel your membership for any reason by telling the HMO, **in writing,** you want to leave the plan. Sign and date your request and send it to the HMO office or to the Social Security Office. It may be a good idea to send it certified mail (return receipt requested) if you want a record of when you sent it. Keep a copy of your letter. Your coverage under the Medicare fee-for-service system will begin the first day of the following month the HMO or Social Security received your request.

To learn more about your rights to care as a Medicare beneficiary, contact your managed care plan, or read the booklet titled **A Massachusetts Guide to Medicare and Medicare HMO APPEALS**, available from your local SHINE Program or the Executive Office of Elder Affairs, 1 Ashburton lace, 5th floor, Boston, MA 02108. 1-800-882-2003 or TDD: 1-800-872-0166 or you may visit the Executive Office of Elder Affairs' web site at www.state.ma.us\elder which features some of the SHINE Health Insurance Counseling Program's publications.

For free legal advice and help with a Medicare appeal, contact the Massachusetts Medicare Advocacy Project at 1-800-323-3205 or 617-371-1234 (TTY: 617-371-1228)

BENEFITS COMPARISON CHART

BENEFIT	EMPLOYER PLAN NAME OF PLAN	MANAGED CARE NAME OF PLAN	MEDIGAP PLAN NAME OF PLAN	OTHER NAME OF PLAN
Hospital Deductible				
Medical Deductible				
Hospital Co-payments				
Medical Co-payments				
Annual Out of Pocket Limit				
Prescription Drugs				
Foreign Travel/Out of Area				
Monthly Premium				
Preventive Care (besides flu shots, mammograms)				
Out of Pocket Maximum				
OTHER _____ ***(Eye exam, glasses, hearing aids)***				

4. Medicaid and the Medicare Buy In Programs: MEDICAID, QMB & SLMB and QI

Health Insurance or Help Paying for Medicare Costs for People with Low Incomes

"I am living on a fixed income and I can barely afford Medicare, much less any other insurance!" Several Massachusetts health insurance programs may be tremendously helpful as they will pay for medical costs for low income Medicare beneficiaries.

Is there any program that will give me more in monthly income as well as Medicaid?
Supplemental Security Income (SSI) is a monthly cash benefit that helps low-income seniors 65 years or older, as well as blind or disabled adults of any age. If you meet the income and asset requirements, the SSI program pays the elder a monthly income check in addition to their Social Security check. And, anyone receiving SSI income is also automatically **eligible for Medicaid**. To find our more about SSI or to apply, call Social Security at **1-800-772-1213**; or **TDD: 1-800-325-0778 or visit your local Social Security Office.**

Medicaid Health Insurance Coverage
Medicaid wraps around your Medicare coverage to pay many of the gaps in Medicare, such as premiums, deductibles, co-payments, and extras like prescription drugs and eyeglasses. You may enroll into Medicaid if:

- for an individual, your income is **$736 or less** per month and your assets are **$2,000 or less**.
- for a married couple, your income is **$988 or less** per month and your assets are **$3,000 or less**. (Different asset and income rules are used when a married person needs Medicaid for nursing home care.)

Qualified Medicare Beneficiary Program (QMB)
QMB pays the Medicare premiums, deductibles, and co-payments. No extra medical benefits are covered, but QMB would pay the cost of a Hospital Deductible ($792 in 2001), the part B annual $100 deductible, and all the 20% co-payments for Part B services like doctors' bills. You can enroll into QMB if:

- for an individual, your income is **$736 or less** per month and your assets are **$4,000 or less**.
- for a married couple, you income is **$988 or less** per month and your assets are **$6,000 or less**.

Specified Low-Income Medicare Beneficiary Program (SLMB) and Qualifying Individuals - 1 (QI-1) Programs
SLMB and the QI-1 Programs pays for your monthly Medicare Part B premium. This single benefit is significant. You will save $600 each year in Medicare premiums alone if you enroll. You may be eligible if:

- for an individual, your income is **$987 or less** per month and your assets are **$4,000 or less.**
- for a married couple, your income is **$1,327 or less** per month and your assets are **$6,000 or less.**

Note: The asset limits listed above for Medicaid, QMB and SLMB do not include your home, automobile and certain burial funds and contracts.

<u>The Qualifying Individuals - 2 (QI-2) Program</u>

The QI-2 Program pays for your a small portion of the monthly Medicare Part B premium. This single benefit totals $37.08 per year. You may be eligible if:

- for an individual, your income is **$1,273 or less** per month and your assets are **$4,000 or less.**
- for a married couple, your income is **$1,714 or less** per month and your assets are **$6,000 or less.**

<u>"What do I need to do to apply for Medicaid?"</u>

To apply for Medicaid, QMB, SLMB or the QI programs, call the MassHealth Customer Service Hotline at 1-800-841-2900 or any of the four MassHealth Enrollment Centers listed below to ask for an application form.

You will need to complete and mail the application form to any of the three MassHealth Enrollment Centers listed above. If you prefer to meet with a Medicaid worker, you can stop by any of the Centers. You should receive a letter from the Division of Medical Assistance indicating what documents or verifications will be needed to process your application. When all your paperwork is complete, a decision should be made within 45 days.

Revere MassHealth Enrollment Center 300 Ocean Ave. Revere, MA 02151	(781) 485-2500 or 800-322-1448 TTY: 800-608-3300 (781) 485-2400 (Fax)
Springfield MassHealth Enrollment Center 311 State Street Springfield, MA 01105	800-332-5545 or 800-321-2007 (413) 785-4100 TTY: 800-596-1276 (413) 785-4180 (Fax)
Taunton MassHealth Enrollment Center 21-A Spring Street Taunton, MA 02180	800-242-1340 (508) 828-4600 TTY: 800-596-1272

There is also a MassHealth Enrollment Center in Tewksbury that will assist clients who wish to walk-in and apply for Medical Assistance. Also, once your application is approved and you have any questions or problems concerning Medicaid, the Tewksbury office will have your records.

MassHealth Enrollment Center in Tewksbury
367 East Main St.
Tewksbury, MA
01876-1957

800-408-1253 or 978-262-9100
800-231-5698 TTY
978-262-9212 (Fax)

Documentation Required to Accompany Applications

Copies of important documents are needed to prove certain facts you declare on an application. The documentation needed varies with each program. The following list identifies what is required per program.

SSI, Medicaid and QMB Programs

- Copy of Medicare card
- Copy of all health insurance cards plus a copy of a recent premium bill
- Copy of the most recent bank statement or pass book
- Copy of Social Security award letter
- Copy of other monthly income checks such as pension or retirement check
- Copy of real estate tax bill, if you own real estate
- Copy of rent receipt or cancelled rent check, if applicable
- Copy of life insurance policy showing current cash surrender value
- Copy of payment book or finance statement for automobile, if applicable
- Copy of any other document showing the value of any other assets (such as bonds certificates, mutual funds, a pre-paid burial contract or burial plot)
- Copy of birth certificate

Medicare Buy In Programs: SLMB, QI-1 and QI-2

You can self-declare your income and assets. You are not required to submit any documents to prove your income or assets.

5. Long Term Care Insurance

"How will I pay for long-term care?"

Long-term care is the name given to the medical, personal, and social services you might need if, because of an accident, an illness, or just growing frail, you are unable to perform certain functions ***independently or on your own*** for an extended period.

Long-Term Care is expensive!

Long-term care is one of the most expensive, but least covered health care costs you may encounter. In Massachusetts:

- Nursing home care can cost $36,000 to $75,000 per year
- Home health care can cost $40 to $50 per visit
- Adult Day Care can cost $30 to $50 per day

Most pieces of health insurance cover very little of the cost of long-term care.

- Medicare pays a maximum of 100 days of nursing home care and a certain amount of home health care only if you need skilled care. Only 2% of Medicare enrollees who need nursing home or home health care meet Medicare's strict requirements for coverage.
- Retiree plans may pay the Medicare coinsurance for nursing home care for a short period.
- Medigap policies pay only the Medicare coinsurance (days 21-100) per benefit period for skilled nursing facility care.
- Medicare HMO plans usually pay up to 100 days per benefit period for skilled nursing facility care.

Will Medicaid pay for long-term care?

Medicaid will pay long-term care costs in a nursing home and sometimes at home as well. However, Medicaid is available only when single persons have no more remaining in assets than $2,000. If you are married, your spouse living at home would be permitted to keep up to $87,000 (or more, after an appeal), of your joint assets as well as $1,353 to $2,175 of income monthly as a spousal maintenance needs allowance.

Is long-term care insurance the answer?

Should everyone have long-term care insurance to pay for long-term care costs? Ideally, yes. But long-term care insurance, like the long-term care service you are insuring against, is expensive. So, long-term care insurance is only appropriate for those who can afford the premiums, both now and in the future. It is ***not*** appropriate for those whose assets total are less than the cost of one year in a nursing home.

Favorable tax treatment affecting long term care insurance policies and uninsured long term care expenses.

Favorable tax treatment may be available for certain types of long term care expenses and policies. For example:

- premiums for **qualified** insurance policies will be deductible as medical expenses (for those who itemize medical deductions)
- LTC benefits received from **qualified** policies may be received by the insured policy holder on a tax-free basis;
- uninsured LTC expenses **not covered by insurance** may be deductible as medical expenses (under certain restrictions);
- Employer-paid premiums of LTC insurance may not be treated as income to the insured employee.
- Tax-qualified plans must coordinate with Medicare; so if Medicare pays for a service first, the LTC policy would pay as a secondary payer for the same service.
- A non-forfeiture benefit option must be offered during the sale of all qualified policies. This does not mean the benefit will be a standard feature built into every policy.

The IRS must finalize definitions for qualified policies and submit which would get such treatment. See a tax advisor for details.

There is no general rule for everyone to use to determine whether long-term care insurance is suitable. When deciding whether long-term care insurance is appropriate for *you*, consider the following:

- **Your ability to afford long-term care insurance.** Senior advocates suggest that a long-term care insurance premium that exceeds 5% to 7% of your annual income is probably unaffordable.
- **Your ability to qualify for a long-term care insurance policy.** Unless you are in relatively good health, insurers probably will not sell you a long-term care insurance policy.
- **Your goals.** Do you wish to preserve assets for a spouse or to leave an inheritance to your children?
- **Your health status, lifestyle, family history, life expectancy.** Do you expect chronic conditions?
- **Your gender, your marital status.** Are you female, single or widowed? Your chances of needing formal long-term care services are greater when informal (unpaid) help with long-term care is not available to you.
- **Your support circle.** Are your family and friends in distant locations or otherwise unable to provide care if you should need it? Long-term care insurance may make sense.

For more information about the Long Term Care Medicaid application, application process or general questions about Medicaid laws surrounding long term care insurance, call the MassHealth Customer Services at 1-800-841-2900 or any of the four MassHealth Enrollment Centers listed on page 35.

To read more about long-term care insurance:
For a copy of "A Shopper's Guide to Long-Term Care Insurance," contact the National Association of Insurance Commissioners at 1-816-374-7259 or write to: NAIC, 120 W. 12th Street, Suite 1100, Kansas City, Missouri 64105.

"Your Options for Financing Long-Term Care: A Massachusetts Guide" may be obtained by calling or writing the Division of Insurance at One South Station, Boston, MA 02110, phone: 1-617-521-7777 (TTD: 617-521-7490).

A "LTC Self-Assessment Guide" with Bibliography is available from the Information and Referral Unit of the Executive Office of Elder Affairs at 1-617-727-7750 (TTD: 800-872-0166).

6. Non-Group Health Insurance For Individuals

Non-Group Health Insurance Plans for Individuals and Families in Massachusetts

Massachusetts residents who are not eligible for employer-based health coverage may buy non-group health care insurance or coverage from any carrier offering plans. As of October 1997, carriers offering this coverage will not be able to refuse any applicants based on their health, and carriers cannot impose pre-existing condition exclusions or waiting periods. And, all carriers must offer one of three model coverage packages.

Who is eligible?

Individuals and their dependents are eligible for this coverage if :

- they are Massachusetts residents;
- they do not have access to group health insurance through their employer or spouse's workplace;
- they are not eligible for COBRA (continuation of employer group health plan) coverage, or are no longer eligible for COBRA coverage;
- they are not enrolled in Medicare or Medicaid; and
- they are not self-employed. (Under Massachusetts law, self-employed persons are not eligible for non-group health coverage because they may buy coverage from any insurance carrier which offers coverage to small businesses).

When to enroll

There is an Annual Enrollment Period, two months in length, held September 1 - October 31, with coverage to be effective on December 1.

3 Model Coverage Packages for Non-group Plans

Under Massachusetts law, carriers must offer a plan (or plans) that includes a standard set of benefits including emergency care, hospital services, physician services, certain preventive treatments, and outpatient prescription drugs. Carriers may offer more than the standard stet of benefits. Carriers may also charge deductibles before reimbursing for services, and may also charge co-payments for services covered under the plan. However, these deductibles and cost-sharing co-payments cannot be greater than the amounts approved by the Division of Insurance.

The three types of plans vary according to their structure and how they deliver medical services.

1. The first is the **Medical Plan.** The medical plans do not have any restrictions on choice of medical providers. This is a traditional health plan in which the insured may go to any licensed hospital, doctor, or provider for treatment. Under the non-group standard requirements, the insured must meet an annual deductible for $700 per member/$1,400 per family, and then pay 20% of the cost for most covered services.

2. The second model plan is the **Preferred Provider Plan,** which contains incentives for using a set of preferred providers. In a preferred provider plan, the insured may go to any licensed hospital, doctor or provider, but he will pay a smaller co-payment if he visits medical providers listed on the preferred list of providers. Under this model plan, the insured must meet an annual deductible of $250 per member/$500 per family and then pay 10% of the cost of covered services from the preferred providers and 30% of the cost of services received from other non-preferred providers.

3. The third and final model plan is the **Managed Care Plan,** offered by HMOs with closed networks of providers. Except in cases of emergency and specific situations, the insured must use the providers of the HMO network in order to receive benefits. In this standard model plan, there is no deductible. There are co-payments ranging from $15 for each office visit to $500 for a hospital stay.

"Guarantee Issue Plans" Means No Health Screening

The participating health insurance carriers cannot deny any applicant nor impose any waiting periods or coverage limitations because of medical conditions or prior medical history. They can only deny coverage if the applicant does not meet all the application criteria listed above, or if an applicant lives outside the service area (for plans where residency within the plans' service area is relevant), or if the insured does not pay the plan premiums, or, if the carrier learned that the insured submitted false information on their application or other plan documents, such as claim forms.

Cost for Non-group Health Insurance Plans

Carriers will offer a plan with rates that will vary based upon the applicant's age, family type (both individual and family coverage is available), and place of residence.

For More Information and a List of Current Carriers

You or our client may contact the Division of Insurance at 617-521-7777 (Boston) or 413-785-5526 (Springfield) (or TDD: 617-521-7490) for information about pricing, and a list of approved plans for families in your area of the state. During 1997's initial enrollment period, 23 separate plans were available from 19 different carriers.

"Are other limited benefit policies necessary?"

As of October 1, 1997, other limited benefit policies can no longer be sold in Massachusetts. The only plans that can be sold are non-group "guarantee issue" health insurance plans discussed here. Check the limited benefit policy that you already have. Many people buy limited benefit policies years before Medicare enrollment and neglect to evaluate whether or not the policy is necessary when they get Medicare. Many hospital plans reduce benefits by 50% after age 65!

Use great caution in any health insurance policy purchase to avoid paying for coverage you may not need. **Choose what you need; do not be "sold"!**

How to buy health insurance as an individual

- Call the Massachusetts Division of Insurance at 1-617-521-7777 (TDD: 617-521-7490) to get a list of companies that sell in your county. Or, you may call a local HMO, insurance broker or agent to ask about what policies they can provide.
- If you do want an agent to visit, ask him or her to make an appointment. Have a family member or friend with you. **Listen carefully. Take time to decide. Never purchase immediately.** Take time to talk to family and friends.
- High pressure sales tactics are not permitted by Massachusetts insurance regulation. Most agents are honest and present accurate information. Only a small minority use inappropriate tactics. Report high pressure sales to the Division of insurance immediately.
- If you do buy, remember that you have a 10 to 30 days **free look period** once you receive your policy to return it for full refund. Check your policy or ask your agent how many days you have for the **free look** period.

For a List of Insurers Selling Insurance or to Register a Complaint about an Insurance Company or Managed Care Organization

Call the Massachusetts Division of Insurance at 1-617-521-7777 (TDD: 617-521-7490) whenever sales agent of company behavior appears to be incorrect. Also, you may send in your written complaint to: **Division of Insurance, One South Station, Boston, MA 02210.**

7. Other Health Benefits Programs

Are there any other programs to help people in need of medical care?
Yes, there are several other programs available if you have a low monthly income and limited assets.

Medicaid and Supplemental Security Income (SSI)
SSI is a cash benefit to help low-income seniors 65 years or older and the blind or disabled of any age. If you meet the income and asset requirements, the program pays a monthly check and guarantees automatic **eligibility for Medicaid**. To apply, call Social Security at **1-800-772-1213**; or **TDD: 1-800-325-0778.**

Preventive Health Services Offered at Federally Qualified Health Centers
Another option that can help limit your health care costs is to receive health services at a Federally Qualified Health Center (FQHC). Medicare pays for additional health services at the FQHC that are not otherwise Medicare-covered services, such as preventive care services, including:

- routine physical examinations
- screening and diagnostic tests for the detection of vision and hearing problems
- administration of certain vaccines

You do not have to pay the $100 Medicare Part B deductible for services provided at a FQHC. While the Part B coinsurance applies to all FQHC services, guidelines allow FQHCs to waive it in some instances. Any Medicare beneficiary may seek services at a FQHC. To find out whether one of these centers serves your area, call **1-800-475-8455 or 617-426-2225.**

MassHealth Insurance Coverage for Disabled or Low-Income or Long Term Unemployed Adults and Families
This state program provides health care benefits to disabled working adults and disabled children, low income workers and long term unemployed individuals. For general information about MassHealth benefits call the MassHealth Customer Service Center at **1-800-841-2900. TDD: 1-800-497-4648.**

Free Hospital Care or Partial Free Care
Hospitals are required to provide free hospital care or partial free care for services billed by the hospital. Call your local hospital's billing or customer service department to apply. For general information, you may contact the Department of Medical Security at **1-617-988-3138.**

Cut the Cost of Prescription Drugs

1. **Coverage through Medigap Insurance**
2. **Coverage through HMOs**
3. **Massachusetts' Prescription Advantage Insurance Plan**
4. **Free Prescription Drugs from Drug Manufacturers**
5. **Veteran's Benefits**
6. **Cost Cutting Tips - Generic versus Brand Label Drugs and Comparing Prices**

Prescription costs are rising and more and more Medicare beneficiaries are having difficulty paying for their needed medications. Unfortunately, many elders may be at risk because they may be taking less than the prescribed amount to make the medication last longer or not taking the medication at all! We have compiled the following list to help elders and Medicare beneficiaries cut of the costs associated with the medications they need.

Coverage Through Insurance

"Medigap" - Medicare Supplemental Insurance

In Massachusetts, companies who sell Medigap insurance must sell at least one product with an unlimited drug benefit (no dollar limit). This policy form is named "Medicare Supplement #2." There is a $35 dollar deductible for every 3-month period, and then the policy must pay for brand name drugs at 80% and pay for 100% of the cost of generic drugs. The cost of a Medigap policy may be less than your drug costs if your annual drug cost is greater than $3,600 per year.

Some companies limit sales to February and March only, when all Medigap companies must sell their policies to any Medicare beneficiary who applies (unless the beneficiary is under the age of 65 and the sole reason they have Medicare is due to having end stage renal disease.) Some companies sell throughout the year. At other times of the year, you can buy a Medigap policy if you are "initially eligible". See pages for more information about when Medigap enrollment may occur.

Medicare HMOs

Medicare HMOs cap the amount they will pay for prescription drugs for any 3-month period.

1. If you are enrolled in a Medicare HMO, contact your HMO plan to find out what drug benefit they provide for you. Medicare HMOs provide some prescription drug coverage. Check each plan for a cap. They may charge a co-payment per prescription, too.

2. If your HMO plan is capping its drug benefits, find out if its using an annual or quarterly (3-month) dollar limit. Also, ask how the plan will count each drug you buy toward the cap. Some plans may use retail prices (higher) while others will use discounted prices (lower) when it calculates how much of your drug benefit you have used each quarter (every three months).
3. Find out if the plan can obtain a 60 or 90-day supply of medicine from its local pharmacies instead of a 30-day supply. Ask if the plan uses or requires the use of a mail order pharmacy for 90-day prescriptions. You can reduce your overall costs using a mail order pharmacy.
4. Ask how the plan keeps track of your purchases and how you can be informed of what amount you have left before you will have to pay out of our won pocket.
5. Some HMO plans allow members to buy additional drugs (above the cap) at the same discounted price the HMO pays. Ask the plan for more details.

- **Two HMOs had transitional drug assistance plans in 2000 for members who were enrolled in the plan's prescription benefit plan as of December 1, 1998.** If you were a member of either the Harvard Pilgrim Health Care First Seniority HMO or Blue Cross/ Blue Shield Blue Care 65 HMO as of December 1, 1998 you can get help from these plans from their Transitional Drug Assistance Program. You can **apply even if you are no longer a member of the plan.** For further details, call the HMO.

For **Blue Cross Blue Shield - Blue Care 65**, Call 1-800-200-4255 or TTY: 1- 800-523-2487.
For **Harvard Pilgrim Health Care - First Seniority** – Contact the Lash Group at 1 - 800-789-5147 or TTY: 1-800-735-2962.

MassHealth (Medicaid)

MassHealth (also known as "Medicaid" or "Medical Assistance") offers many types of health insurance coverage for individuals over the age of 65, individuals with disabilities, children and families, and long-term unemployed adults.

For individuals over the age of 65, full health insurance coverage with full prescription drug coverage from MassHealth is available to individuals who have monthly incomes less than $736 per month for single persons or $988 per month for married couples. See pages for more details. Please call MassHealth at 1-800-841-2900 (TTY: 800-608-3300) for more details and application forms. When you call, ask about the "Medicare Buy-In Programs".

Prescription Advantage

- Prescription Advantage is an insurance plan sponsored by the Commonwealth of Massachusetts that will begin on April 1, 2001. Prescription Advantage provides an unlimited drug benefit, including coverage for insulin and disposable insulin syringes and needles. As of April 1, 2001, to be eligible for the plan, you must be a Massachusetts resident who is not eligible for MassHealth benefits and is:
- Over 65 years of age; or
- An adult with disabilities under age 65 with a gross annual household income less than $16,152 (individual) or $21,828 (married couple) who works for pay less than 40 hours per month; or,
- Enrolled in the PHARMACY Program or the PHARMACY Program Plus as of March 31, 2001.

All enrollees of Prescription Advantage will pay a monthly premium, yearly deductible and prescription co-payments based upon their annual household income. However, the Commonwealth of Massachusetts will pay the premiums and deductibles for individuals and couples with incomes less than $16,152 (individual) or $21,828 (married couple).

- The monthly premiums for the first year range between $15 and $82 per month.
- The deductibles for the first year range between $100 and $500.
- Stop-Loss Protection – Yearly maximum out-of-pocket costs paid by each enrollee for deductible and co-payments is the lesser of either $2,000 or 10% of the member's annual gross household income, whichever is less.
- You may join anytime within the first year. Thereafter, limited periods of enrollment may be established.
- Call 1-800-AGE-INFO (1-800-243-4636) (TTY: 1-877-610-0241 for the hearing and speech impaired) for information and an enrollment form for Prescription Advantage.

Retiree Health Insurance Plans

If you have a retiree health insurance plans from your past employer, re-read the policy or contact your employer to find out the full extent of the drug coverage it provides.

Free Drug Programs by Drug and Pharmaceutical Companies

Free Prescription Drug Program: Many drug companies offer free prescription drugs to individuals who can not afford to buy all of their medications. Your doctor wants to know if your cannot afford to take your medications. Contact your doctor and ask him or her to help you apply for free drugs from the drug company. Your doctor will need to call the drug company and ask for its free drug application materials. Your doctor must sign a letter or application for you. Ask your pharmacist to give you a printed list of your monthly medications and prices. Ask the pharmacist to write the drug manufacturer's name next to each medication on the list. Then give the list to your doctor so he or she can contact the company for you and make the request.

Please contact a SHINE Counselor at 1-800-882-2003 TTY 1800-872-0166 if help is needed applying for this program.

Veterans Benefits

Veteran's Benefits - There are prescription benefits available to veterans. To receive health care, most veterans must be enrolled. You can apply for enrollment at any VA health care facility or Veterans Agent office at any time of year. Application forms may also be obtained by calling toll-free to 1-877-222-VETS (1-877-222-8387) or accessing information on the Internet at www.va.gov/health/elig. Also, your local Veterans Agent will have information about enrolling for VA health benefits as well as other assistance available for veterans.

Cost Cutting Tips for Everyone to Use

1. You may be able to save some money by using **generic drugs** instead of **brand name drugs**. Generic drugs are less expensive than brand name drugs - talk to your doctor or local pharmacist to learn if there is a generic drug you could substitute for a brand name drug you take now.

2. If you currently buy prescription drugs for some type of ongoing medical condition, take a list of all your medications to your pharmacist and ask the pharmacist to print out the retail prices for all your current medications. Knowing how much the drugs cost will help you explore new options and compare prices between competing stores. Drug costs can vary significantly between local pharmacies. You may be able to save money by price shopping between pharmacies.

Emergency Cash Relief and Financial Benefits Programs

Your local **Council on Aging** has information about emergency cash relief funds available in your town or community. Contact your Council on Aging to find out what local community resources can help you.

Your Council on Aging can also explain the details about many other budget saving programs available in your city or town. For example, you can learn how to cut your real estate taxes, reduce your food bill, or find affordable transportation by calling or visiting your local senior center or Council on Aging.

Disclaimer: The Executive Office of Elder Affairs does not sell, recommend, promote, or endorse any prescription plans. The information listed is a guide to assist consumers. Every effort has been made to ensure the accuracy of this information; however, some of the information may be subject to correction. This list will be updated periodically.

Medicare Telephone Numbers to Note

SHINE - Serving Health Information Needs Elders Health Insurance Counseling Program 1-800-AGE-INFO (1-800-243-4636) (TTY: 1-800-872-0166)	Free and objective health insurance of counseling program for Medicare beneficiaries and elders sponsored by the Mass. Executive Office of Elder Affairs.
Medicare Part B Carrier & State Fraud and Abuse Hotline 1-800-882-1228	Medicare Part B claims and coverage questions (except DME) as and fraud and abuse complaints.
Durable Medical Equipment (DME) Carrier 800-842-2052	Durable medical equipment claims and coverage questions.
Medicare Part A Intermediary 1-888-896-4997	Medicare Part A claims and coverage questions.
Mass Peer Review Organization 1-800-252-5533	Investigates complaints about poor quality of care received by a Medicare beneficiary from a Medicare HMO or any hospital, nursing facility or home health agency.
Centers for Medicare & Medicaid Services (CMS) Boston Regional Office Medicare Beneficiary Services 1-617-565-1232	Assistance for complex Medicare issues.
MassHealth for Medicaid, QMB, and SLMB And QI Programs 1-800-841-2900	Eligibility, applications and coverage information.
Medicare Advocacy Project 1-800-323-3205	Provides free advice and legal aid to Medicare beneficiaries.

National Medicare Fraud and Abuse Hotline 1-800-447-8477	Refers reports about Medicare fraud and abuse to Mass. Medicare carrier.
Social Security Administration 1-800-772-1213	Medicare enrollment; issues new Medicare cards.
Pharmacy Program 1-800-249-4696 1-800-AGE-INFO	Helps elders and adults with disabilities to buy prescription drugs.
Medicare Hotline 1-800-MEDICARE (1-800-633-4227)	Order publications
Dentistry for All 1-800-342-8747	Discount dentistry referral program.
MA Dept. of Public Health 1-800-462-5540	Investigates quality of care complaints and reviews hospital discharge planning by acute care hospitals.
Project Bread 1-800-645-8333	Food stamp applications

Internet Sites

www.medicare.gov - see the latest versions of Medicare publications about benefits and supplemental insurance options. Access Medicare Compare, a database of managed care plans sorted by zip code which provides benefits and quality of care information on local plans.

www.healthfinder.gov – this gateway site lists dozens of health-related sources, both governmental and non-governmental.

www.ncqa.org – the National Committee for Quality Assurance accredits managed care organizations and produces report cards evaluating the quality of care in individual plans.

www.state.ma.us\elder – Executive Office of Elder Affairs web site with some of the SHINE Health Insurance Counseling Program's most popular publications and consumer charts.

PART II

APPEALS

A Massachusetts Guide to Medicare & Medicare HMO APPEALS

----what you need to know about
Hospital and Medical Appeals

Commonwealth of Massachusetts
Executive Office of Elder Affairs

The Serving Health Information Needs of Elders (SHINE) Health Insurance Counseling Program

Jane Swift
Governor

Lillian Glickman
Secretary

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Commonwealth of Massachusetts
Executive Office of Elder Affairs

A Massachusetts Guide to Medicare & Medicare HMO APPEALS

----what you need to know about Hospital and Medical Appeals

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(SHINE) Health Insurance Counseling Program

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The Executive Office of Elder Affairs does not sell, recommend, promote, or endorse any insurance product, company or agent. The information in this guide is being provided to assist consumers in making informed purchasing decisions. Every effort has been made to ensure the accuracy of this information; however, some of the information may be subject to correction. This guide will be updated periodically.

Acknowledgments

This consumer booklet has been developed by the Executive Office of Elder Affairs Serving Health Information Needs of Elders (SHINE) Health Insurance Counseling Program. SHINE's counseling and information services are free and confidential. SHINE is funded through grants from the United States Health Care Financing Administration and the Massachusetts Councils on Aging that are administered by the Executive Office of Elder Affairs.

The Executive Office of Elder Affairs recognizes that most Medicare beneficiaries are unaware of their rights to appeal medical decisions. This booklet was developed to give the health care consumer a better understanding of the Medicare appeal systems so they can improve the quality of care they receive. This booklet explains how to start a Medicare or Medicare HMO appeal.

A SHINE Telephone List appears at the end of this booklet. You may also contact the Executive Office of Elder Affairs at 1-800-AGE-INFO (1-800-243-4636) (TTY: 1-800-872-0166), your Council on Aging or Area Agency on Aging in your area to learn about the SHINE Program nearest you.

Note: The SHINE Program welcomes requests from not-for-profit organizations to excerpt or utilize the contents of this publication. Please contact the SHINE Program at the Executive Office of Elder Affairs, 1 Ashburton Place, 5th floor, Boston, MA, 02108 for permission. S:\SHINE Unit\EOEA Web Site Materials\2000 Materials\P1 APPEALS.doc

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Introduction

Whether you received care from a hospital (inpatient or outpatient), a hospital emergency room, a skilled nursing facility, a home health agency, or outpatient surgery center, you have the right to question any part of the health care provided to you.

If you disagree with a decision on the amount Medicare (or a Medicare HMO) will pay on a claim or whether services you received are covered by Medicare (or the HMO), you have the right to ask for that decision to be reviewed by another official of the Medicare system.. There are separate appeals processes for Medicare Part A services, Medicare Part B services, and Medicare HMOs.

The appeal process takes time and a lot of patience in order to succeed. However, it can be important to exercise your right to receive the highest quality of care you are entitled to receive. To improve the system of health care for yourself and every other Medicare beneficiary, it is important to appeal a denial of a service whenever you believe the services being denied are Medicare or Medicare HMO covered services to which you are entitled.

Most appeals involve issues relating to:

- whether or not a service is medically necessary or appropriate for the treatment or diagnosis of an illness or injury.
- how much Medicare will pay towards a claim.
- whether or not a nursing home or hospital should continue providing medical services to a patient at that level of care
- the meaning of "urgent" versus "emergency" care in a Medicare Managed Care Plan (HMO).
- the quality of care they receive from medical staff and in medical settings.

It is important to understand there are two types of notices used in the Medicare system: those that are **not official Medicare determinations** and those that are **official Medicare determinations**. The following are form letters or oral exchanges between a medical provider and a Medicare beneficiary; they are **not official Medicare notices**:

- Notices of Non-Coverage (NNC)
  [a SNF may use a "Skilled Nursing Facility Termination Notice"]
- verbal discussions with providers in which Medicare services are terminated or refused.

Official Medicare determinations are issued by the Medicare intermediary, MassPRO, or the Medicare carrier and include the following:

- Notice of Initial Determination
- Notice of Utilization
- Explanation of Medicare Benefits (EOMBs)
- Reconsideration Determination

APPEALS FOR MEDICARE PART A SERVICES

Skilled nursing facility services and home health benefits in the fee-for-service system.

CASE 1: *You have been receiving medical services as a patient in a **skilled nursing facility**, but have been told by the facility staff that Medicare won't cover your stay after a few more days. What can you do?*

CASE 2: *Or, you want to engage the services of a **home health company**, but they do not believe you meet one of Medicare's guidelines for home health care. What can you do?*

STEP 1 - GET A WRITTEN NOTICE OF NON-COVERAGE (NNC)

A Part A provider should give you a written NNC to explain the services you seek will not be paid for by Medicare. If they have spoken to you about "no coverage for benefits", ask them to give you a written NNC.

STEP 2 - ASK THE PROVIDER TO REQUEST AN OFFICIAL MEDICARE DETERMINATION

If you so request, the provider must submit a **"demand bill"** (also referred to as a **"no-payment bill"**) to the Medicare intermediary on your behalf. A Medicare beneficiary always has the right to have a claim submitted to Medicare. Therefore, when a provider decides that a service is not covered, a bill at the request of the beneficiary can be submitted. The beneficiary must ask the Part A provider to get the official Medicare determination in order to develop the right to request further appeals. *When beneficiaries are unaware of their rights, they wrongly assume the provider's NNC is an official Medicare determination when, in fact, it is not an official determination by Medicare!*

STEP 3 - RECEIVE THE OFFICIAL MEDICARE DETERMINATION IN THE FORM OF A NOTICE OF UTILIZATION

Medicare sends you a Notice of Utilization which states its ruling. If you do not receive this official determination within thirty days, then contact the local intermediary. If they rule in your favor, then you get the services requested paid for by Medicare. However, if you still disagree with the ruling, ask for a Reconsideration Determination.

STEP 4 - REQUEST A RECONSIDERATION DETERMINATION

If you still disagree with the ruling in the Notice of Utilization, ask for a Reconsideration Determination by writing a letter to the intermediary. Its address is on the recent Notice of Utilization. Include in your written request a copy of the NNC and Notice of Utilization. You have 60 days from the date you received the Notice of Utilization to make this request.

STEPS 5 AND BEYOND - INTERMEDIARY SENDS YOU A RECONSIDERATION DETERMINATION

The intermediary will assign someone new to reconsider your case and issue a determination. If they confirm your belief that Medicare services should be provided to you, then you have won. However, if they continue to rule against you, read the instructions on the reconsideration determination to learn about the next appeal step (a hearing before an Administrative Law Judge).

APPEALS FOR MEDICARE PART A SERVICES-
The Hospital pre-admission denial

CASE 3: *You want to have your surgery performed at the local acute care hospital, but the hospital has informed you that you will not be admitted as an inpatient for this procedure. What can you do?*

INTRODUCTION

If a hospital decides not to admit you to the hospital, it must give you its decision in writing. However, this decision is **not an official Medicare determination**. In order to get an official Medicare determination, follow these steps:

STEP 1 -
ASK MASSPRO TO REVIEW THE HOSPITAL'S DECISION

You must ask MassPRO to review the hospital's decision. You can ask for an immediate review if you contact MassPRO within three days of the date you received the hospital's decision. You can contact MassPRO by telephone at **1-800-252-5533** or in writing at MassPRO, 235 Wyman Street, Waltham, MA 02154-1231. Otherwise, you have 30 days to ask MassPRO to make a review. If the hospital had already consulted with MassPRO while making its decision, then you are actually asking MassPRO to reconsider the pre-admission denial.

STEP 2 -
RECEIVE MASSPRO'S DETERMINATION

MassPRO will review the hospital's decision and send out an official Medicare determination. If MassPRO agrees with you and decides Medicare should pay for your stay in the hospital, then the hospital will be expected to admit you. If MassPRO agrees with the hospital, the reconsideration determination will explain your rights and the next steps to take to continue the appeal.

APPEALS FOR MEDICARE PART A SERVICES - Inpatient Hospital Notice of Non-Coverage

CASE 4: *You have been in the hospital for ten days because you have a broken hip. The hospital issues a Notice of Non-Coverage to you stating that in three days time you will be discharged home. You think the discharge is premature. What can you do?*

INTRODUCTION

As a Medicare patient, you have the right to remain in the hospital to receive all necessary care for the proper diagnosis and treatment of your illness or injury.

STEP 1 - REQUEST TO RECEIVE THE NOTICE OF NON-COVERAGE IN WRITING

The hospital must give you a written notice which explains their belief Medicare will no longer pay for your stay and includes the phone number of the Massachusetts Peer Review Organization (MassPRO).

STEP 2 - ASK MASSPRO TO REVIEW THE HOSPITAL'S DECISION

To request an immediate review, you must contact MassPRO at **1-800-252-5533** by **noon of the next business day** (Saturdays, Sundays and holidays not included) after the date you received the Notice of Non-Coverage. You cannot be charged for any days until noon of the day after MassPro makes its decision, regardless of the outcome of the decision.

If you do not request an immediate review, you will have 30 days to ask MassPRO to make a review. If the hospital had already consulted with MassPRO while making its decision, then you are actually asking MassPRO to reconsider the decision to discharge you from your current Medicare-covered stay in the hospital. You can contact MassPRO by telephone at **1-800-252-5533** or in writing at MassPRO, 235 Wyman Street, Waltham, MA 02154-1231.

STEP 3 - RECEIVE MASSPRO'S DETERMINATION

MassPRO will review the discharge decision and send out an official Medicare determination (if they are reconsidering their previous decision, then it will be a reconsideration determination). If MassPRO agrees with you and decides Medicare should pay for your stay in the hospital, then the hospital will be expected to retain you as an inpatient for the time being. If MassPRO agrees with the hospital, then the determination will also explain your rights and the next steps to take to continue the appeal.

APPEALS FOR MEDICARE PART B SERVICES

Doctor's services, outpatient hospital care, diagnostic services, durable medical equipment and ambulance services.

Typical Case: *EOMBs are often reviewed when coverage is denied, the amounts allowed seem out of line, when claims are denied for insufficient information or omitted facts, or when the medical necessity of certain procedures has not been fully demonstrated when the claim form was submitted by the Part B provider.*

STEP 1 - REQUEST A REVIEW FROM THE CARRIER BY MAIL OR BY TELEPHONE

On the EOMB attach a note saying "**Please review**", sign it, date it, and send it back to the carrier. The carrier's name and address are on the form. If appropriate, a letter from the doctor explaining the medical necessity for the procedure can also be included. You have six months to send in your request for a review.

You may also use the telephone to conduct the review. Between 8 AM and 4 PM, Monday through Friday, you may call the Medicare Carrier for Massachusetts, National Heritage Insurance Corporation, at **1-800-294-2351** to request a review over the telephone. You must still request the review within six months of the date the EOMB was issued.

When you call, be prepared to tell the carrier the following facts:

- your full name
- current address
- your Medicare health insurance claim (HIC) number
- the 13-digit claim control number on the claim you want reviewed (this is on the EOMB)
- and the date of service.

In most cases, the carrier can inform you of its official determination of the review during the telephone call. You will also receive a formal letter or an adjusted EOMB. Follow the instructions on the review determination if a further appeal is necessary. The next step is a fair hearing before a carrier hearing officer.

For appeals concerning durable medical equipment, the carrier for Massachusetts is:

HealthNow
Durable Medical Equipment Regional Carrier
PO Box 6800
Wilkes-Barre, PA 18773-6800
Tel: **1-800-842-2052**

APPEALS FOR MEDICARE HMO - EARLY DISCHARGE FROM A HOSPITAL.

CASE 5: *You have been in the hospital for ten days because you have a broken hip. The HMO issues a Notice of Non-Coverage to you stating that in three days time you will be discharged home. You think the discharge is pre-mature. What can you do?*

INTRODUCTION

As a Medicare HMO patient, you have the right to remain in the hospital to receive all necessary care for the proper diagnosis and treatment of your illness or injury. HMOs have systems in place that let you appeal their payment decisions.

STEP 1 - REQUEST TO RECEIVE THE NOTICE OF NON-COVERAGE IN WRITING - The HMO must give you a written notice, called a "***Notice of Non-Coverage***", which explains your appeal rights and includes the phone number of the Massachusetts Peer Review Organization (MassPRO) to call if you wish to request an ***immediate review***.

STEP 2 - ASK MASSPRO TO REVIEW THE HOSPITAL'S DECISION

To request an immediate review, you must contact MassPRO at **1-800-252-5533** by **noon of the next business day** (Saturdays, Sundays and holidays not included) after the date you received the Notice of Non-Coverage. You cannot be charged for any days until noon of the day after MassPRO makes its decision, regardless of the outcome of the decision.

STEP 3 - RECEIVE MASSPRO'S DETERMINATION - If MassPRO agrees with you and decides the HMO should pay for your continued stay in the hospital, then the hospital will be expected to retain you as an inpatient for the time being. If MassPRO agrees with the HMO, then the determination will also explain your rights and the next steps to take to continue the appeal.

STEP 4 - REQUEST A REVIEW WITH HMO (if you did not request an immediate review) - If you are discharged and you wish to appeal your HMO's decision, you will have 60 days from the date on the NNC to ask your **HMO** to make a review. Send your written request for review to the HMO or the Social Security Office. If the HMO does not rule in your favor, they will automatically send your appeal on to the Center for Health Dispute Resolution (The Center).

STEP 5 - AWAIT THE DETERMINATION OF THE CENTER - The Center must make a determination of the case within 30 working days. If you lose at this stage, the determination will contain instructions on how to request a hearing before the Administrative Law Judge.

APPEALS IN MEDICARE HMOs - STANDARD 14-DAY RECONSIDERATION PROCESS

Case 6: *You have been receiving home health services three times a week with Medicare fee-for-service. You decide to enroll in a Medicare HMO and three weeks later you are informed by the Medicare HMO that they will not pay for any further home health services. You feel you still need assistance and you have contacted your primary care physician about your concerns.*

INTRODUCTION

Medicare beneficiaries in Medicare HMO plans have appeal rights for questioning any medical decision made by HMO staff. A patient may believe they have a medical need for continuing services, or think a certain setting for receiving the medical care is necessary. If an HMO refuses to provided Medicare-covered services you have requested, or decides to reduce or terminate services you have been receiving, then they must give you this decision in writing. If you disagree, then you may file an appeal with your plan.

STEP 1 -
GET THE DECISION IN WRITING - Under the law, the HMO must give you a written denial if the treating physician says you cannot have a particular service. Tell the physician **"I want your decision in writing"**. This denial is called a **"Notice of Initial Determination"**. Along with this notice, the HMO is required to give you an explanation of your appeal rights.

STEP 2 - ASK FOR A RECONSIDERATION IN WRITING - Send your request for a reconsideration to the HMO within 60 days of the date you received the Notice of Initial Determination. In your letter requesting a reconsideration, tell the HMO that you believe the plan has an obligation to provide the service because you believe it is a Medicare-covered service. Also, include a copy of the written Notice of Initial Determination given to you by the physician or the HMO.

STEP 3 - RECEIVE THE RECONSIDERATION DETERMINATION - Your HMO has 14 days to reconsider its initial determination to deny the services or payment for services you believe they should provide. If the HMO agrees with you upon appeal, then they shall provide the service or pay for the care you received. However, if the HMO denies your request on appeal, then it must automatically submit your case for further review to an independent group called the Center for Heath Dispute Resolution.

STEP 4 - AWAIT THE DETERMINATION OF THE CENTER FOR HEALTH DISPUTE RESOULTION (THE CENTER) - The Center must make a determination of the case with 30 working days. If you lose at this stage, the determination will contain instructions on how to request another appeal, a hearing before the Administrative Law Judge.

APPEALS IN MEDICARE HMOs - EXPEDITED 72-HOUR DECISION

INTRODUCTION

Medicare beneficiaries can challenge medical decisions made by HMO doctors and staff. If you do not agree with decisions that have been made by staff of your HMO, you may appeal for coverage for services. Read the steps below to learn how.

Essentially, a Medicare beneficiary may believe a service is medically necessary under Medicare's guidelines, while the plan believes its time to stop services because they are no longer medically necessary. If an HMO disagrees with the beneficiary and denies approval for a new service or decides to stop the continuation of a current service, then beneficiaries can request an appeal. Normally, managed care plans have 14 days to consider a Medicare beneficiary's request for a service which the plan has refused to provide.

However, beginning on August 28, 1997, a new law gives to Medicare beneficiaries the right to receive **a fast decision** from their HMO. This faster decision process is called "an expedited 72-hour organization determination". **An expedited 72-hour decision must be made if the beneficiary's health, life or ability to regain maximum function may be jeopardized by the standard 14-day determination process.** Beneficiaries should ask for a fast decision ("expedited decision" or "expedited organization determination") if they think:

- the HMO will not approve or give him/her medical care or services that should be covered, or
- the HMO is stopping care that he/she still needs, or
- the HMO is decreasing the amount, level or frequency of services.

The HMO will decide whether or not a 72-hour /fast decision indeed needs to be made. If a fast decision is not granted, the appeal will automatically enter into the standard 14-day process. While HMOs have the responsibility for deciding whether or not a request for a fast decision shall be granted, **if a physician makes the request on behalf of the beneficiary, or even if a physician files a statement in support of the request (the statement may be oral or in writing), then the health plan must issue a fast decision.**

HOW TO REQUEST A FAST, EXPEDITED DECISION-

To make a request for a fast 72-hour decision, you may call the HMO and request it, drop-off a written request at an HMO's office, fax the request to the HMO's office, or mail a request to the HMO's Appeal Department. Make your request for a 72-hour decision by stating, "I want an expedited decision, fast decision, or 72-hour decision, or I believe my health should be seriously harmed by waiting 14 days for a standard decision."

- If your request is made by telephone, the plan must write down your request and start its decision process.
- You may hand-deliver your request to an HMO office site, typically their primary care physician's office and/or the HMO's headquarters office.
- You may FAX the request to the plan's Complaints & Appeals Office. If you are a patient in a hospital or skilled nursing facility, ask the facility's staff to FAX the request for you.
- You may mail a written request to the plan's Appeal Department; the 72-hour process will start as soon as they receive your request. Ask your Primary Care Physician or call your HMO to get the telephone number and address of the plan's Appeals and Complaints office. In 1998, all plan handbooks will include instructions on how to start an appeal.

If the plan agrees to perform a 72-hour decision, they must notify you of their decision to either deny or provide services before the 72 hours end. On the other hand, the plan may decide your condition does not require a fast decision. If so, the plan must notify you immediately, and send a written explanation within two working days. The plan's letter must explain that your request will be processed through the standard 14-day decision process. At this point, if you still think you need the services in dispute, then they may ask for an **expedited appeal**.

HOW TO REQUEST AN EXPEDITED APPEAL-

- A beneficiary can request, either orally or in writing, that a second 72-hour review be conducted by the plan; this process is officially called **an expedited appeal**. A beneficiary should ask for an expedited appeal if he/she believes that his/her health or ability to regain maximum function would be seriously jeopardized by waiting for a review under the standard 14-day appeal process.
- Someone can ask for an expedited appeal even though they went through the standard 14-day review process the first time they asked the plan to review its medical decision. A request for an expedited appeal must be considered independently from a request for a fast 72-hour decision and may be granted even if the request for a fast 72-hour decision was rejected.
- If the request for an expedited appeal is not approved, then the plan must automatically enter the request into the standard 14-day appeal process on behalf of the beneficiary (the beneficiary does not need to submit a written request.)

WHO CAN MAKE THE REQUESTS?

A Medicare beneficiary enrolled in an HMO may file the appeal. And, if the enrolled beneficiary wants someone else to make the request for him or her, then they may do so by completing a simple designation form; a sample Designation of Representative Form appears on page 15.

TIME EXTENSIONS

Health plans will be allowed up to 10 extra days to make a decision if the additional time helps the beneficiary's cause, or if the beneficiary asks for more time so he/she can gather and submit more information. Also, if a non-plan doctor who supports the request needs more time to provide all of his/her medical information, then the 72-hour decision period will begin once the non-plan doctor has provided the medical information.

APPEALS FOR MEDICARE HMO MEMBERS WHO ARE IN HOPSITALS

Sometimes, when a Medicare beneficiary is a patient in the hospital, they will be surprised when they are told they will be discharged from the hospital. The HMO must give the patient a written Notice of Non-Coverage that announces the termination of hospital coverage as of a future date. A Medicare patient should not be discharged before they have been given a written notice of discharge as well as a written discharge plan.

This written notice must include information on how to start an immediate review of a hospital discharge if the patient thinks the hospital services are being stopped too soon. The first step in appealing a pre-mature hospital discharge is to immediately call MassPRO at 1-800-252-5533.

Medicare law provides for an immediate PRO review of hospital discharges with financial protection for the beneficiary so long as the beneficiary contacts the PRO by noon of the first working day after receiving the Notice of Non-Coverage. If a Medicare HMO enrollee misses this noon deadline for an immediate PRO review, they may still request an expedited review, but they would loose the financial protection given under the PRO review. So, from a beneficiary's point of view, the beneficiary fares best by using the expedited MassPRO review with the financial protections included.

See page 10 of this guide for a step by step instructions for appealing early discharge decisions by Medicare HMO patients.

Designation of Representative for Expedited HMO Appeal

"I, _____ (name), appoint
_____, (name of representative) to act as my representative in requesting an appeal from my HMO and/or the Health Care Financing Administration, if necessary.

My representative may obtain information about my claim to the same extent that I could, submit additional evidence on my behalf, make statements on my behalf, and make any requests for information related to these proceedings.

I think the plan may be denying me a service to which I am entitled or may be terminating a service before it is medically appropriate to do so."

_____ (Beneficiary Signature) _____ Date

_____ (Representative's signature) _____ Date

Any adult you choose may act as your representative for this appeal. Also, any doctor, working outside or inside your plan, may be appointed to be your representative. Or, you may ask a doctor to provide oral or written statements in support of your request for an appeal. If a doctor supports your request, then the plan ***is required to*** *make a fast, 72-hour decision.*

If you appoint someone to act as your representative, then send this signed statement along with your request for an expedited decision or an expedited appeal of a decision.

DIRECTORY

INTERMEDIARIES - Part A Claims

Aetna Life Insurance Company 203-636-5666
151 Farmington Ave.
Hartford, CT 06156

Associated Hospital Service of Maine 888-896-4997
1515 Hancock Street
Quincy, MA 02169-5228
Processes claims for: ***hospital, SNF, home health, hospice, fraud and abuse***

CARRIERS - Part B Claims

National Heritage Insurance Corp. 800-882-1228
PO Box 1000
Hingham, MA 02044-9191
Processes claims for Part B services and investigates fraud by Part B providers.

HealthNow 800-842-2052
Durable Medical Equipment Region A Carrier
PO Box 6800
Wilkes-Barre, PA 18773-6800
Processes claims for durable medical equipment (DME) and investigates fraud by DME providers.

Railroad Retirement Board's 800-833-4455
UNITEDhealthcare Medicare Claim Service Center
PO Box 1066
2528 Center West Parkway
Augusta, GA 30999-0001

MEDICARE FRAUD & ABUSE HOTLINE

Department of Health & Human Services 800-368-5779
Concerns about abuse of services or billings to Medicare

Office of the Inspector General (Boston) 617-565-2664

QUALITY OF CARE COMPLAINT OFFICES FOR MEDICARE BENEFICIARIES

Massachusetts Peer Review Organization 800-252-5533
(MassPRO) 617-890-0011
235 Wyman Street
Waltham, MA 02154-1231

Medicare Advocacy Office of
the Department of Public Health 800-462-5540

LEGAL SERVICES FOR MEDICARE BENFICIARIES: THE MASSACHUSETTS MEDICARE ADVOCACY PROJECT

Serving Essex, Middlesex, Norfolk and Suffolk counties.
Greater Boston Legal Services 800-323-3205
197 Friend Street 617-371-1234
Boston, MA 02114

Serving Barnstable, Dukes, Nantucket and Plymouth counties.
Legal Services for Cape Cod and Islands 800-742-4107
460 West Main Street 508-775-7020
Hyannis, MA 02601

Serving Bristol and Plymouth counties.
Southeastern Massachusetts Legal Assistance Corp. 800-244-8393
231 Main Street Suite 201 508-586-2110
Brockton, MA 02401

Serving Bristol and Plymouth counties
Southeastern Massachusetts Legal Assistance Corp. 800-929-9721
21 South 6th Street 508-979-7150
New Bedford, MA 02740

Serving Franklin, Hampden, Berkshire and Hampshire counties 800-639-1109
Western Massachusetts Legal Services 413-781-7814
127 State Street
Springfield, MA 01103

Serving Worcester county.
Legal Assistance Corp. of Central Massachusetts 800-649-3718
405 Main Street, 4th Floor 508-752-3718
Worcester, MA 01608

SHINE - Serving Health Information Needs of Elders Program -

The SHINE Program is the health insurance counseling program for senior citizens and Medicare beneficiaries in Massachusetts administered by the Executive Office of Elder Affairs. Contact your Regional SHINE Program Coordinator to discuss your health insurance options and/or set up an appointment with a certified SHINE Counselor. SHINE Counselors can help you understand all your health insurance coverage and appeal rights.

Area # Number	SHINE Regional Program	Telephone Number
Western Mass:		
01	Berkshire County Program	800-957-3557
02	Franklin & Hampshire Counties Regional Program	800-498-4232
03	Hampden County/ Springfield	800-307-4463
Central Mass:		
04	Worcester County/ Central Mass AAA	800-244-3032
05	BayPath / Framingham	800-287-7284
06	HESSCO/Foxboro	800-462-5221
Northeastern Mass:		
07	North Shore Program / Danvers	800-598-1122
08	Minuteman Home Care/ Cambridge & Somerville	781-272-7177
09	Merrimack Valley Elder Services Lawrence	800-892-0890
Eastern Mass:		
10	Mystic Valley Elder Services	781-324-7705
11	West Suburban/ Needham	617-964-5009
12	South Shore Area/Quincy	617-376-1247
13	City of Boston	617-635-3995
Southeastern Mass:		
14 & 18	Cape Cod Regional Program	800-334-9999
15	Plymouth County/ Middleborough COA	800-231-1155
16	Bristol County/Attleboro	800-987-2510
17	Coastline Elder Services	508-999-6400
18	Cape Cod Regional Program	800-334-9999

Medicare Telephone Numbers to Note

SHINE - Serving Health Information Needs of Elders Health Insurance Counseling Program 1-800-AGE-INFO (TTY:800-872-0166)	Free and objective health insurance counseling program for Medicare beneficiaries and elders sponsored by the Mass. Executive Office of Elder Affairs.
Medicare Part B Carrier 1-800-882-1228	Assistance with all Medicare Part B claims and coverage questions.
Medicare Part A Intermediary Part A 1-888-896-4997	Help with Medicare coverage questions and claims.
Mass Peer Review Organization 1-800-252-5533	Investigates complaints about poor quality of care received by a Medicare beneficiary from a Medicare HMO or any hospital, nursing facility or agency.
home health	
Health Care Financing Administration (HCFA) - Medicare Beneficiary Services 1-617-565-1232	Assistance for all Medicare issues.
Medicaid 1-800-841-2900	Eligibility, applications and coverage information.
Medicare Advocacy Project 1-800-323-3205	Provides free advice and free legal aid to Medicare beneficiaries.
Medicare Fraud and Abuse Hotline 1-800-368-5779	Investigates reports about Medicare fraud and abuse.
Social Security Administration and 1-800-772-1213	Medicare enrollment, issues new Medicare cards.
Senior Pharmacy Program 1-800-953-3305	Helps seniors with incomes up to $11,844/year (1997) to buy medicine. Amount increases annually.

Durable Medical Equipment (DME) Carrier
1-800-842-2052

Answers questions and handles durable medical equipment.

PART III

FRAUD & ABUSE

HCFA Medicare Summary Notice (1)

MEDICARE•MEDICAID
Health Care Financing Administration

June 16, 2000

BENFICIARY NAME (4)
STREET ADDRESS
CITY, STATE ZIP CODE

CUSTOMER SERVICE INFORMATION (2)

(3) → **Your Medicare Number: 111-11-1111A**

If you have questions, write or call:
Medicare
555 Medicare Blvd.
Suite 200
Medicare Building
Medicare, US XXXXX-XXXX

Local: (XXX) XXX-XXXX
Toll-free: 1-800-XXX-XXXX
TTY for Hearing Impaired: 1-800-XXX-XXXX

(5)

HELP STOP FRAUD: Beware of telemarketers offering free or discounted Medicare items or services.

This is a summary of claims processed from 5/15/2000 through 6/15/2000

(6)

PART A HOSPITAL INSURANCE-INPATIENT CLAIMS

(7) Dates of Service	(8)	(9) Benefit Days Used	(10) Non-Covered Charges	(11) Deductible and Coinsurance	(12) You May Be Billed	(13) See Notes Section
Claim number 12345-84956-84556-45621 Care Hospital, 124 Sick Lane, Dallas, TX 75555 (14) Referred by: Paul Jones, M.D.						
4/25/00 - 5/9/00		14 days	$0.00	$776.00	$0.00	a,b

(15)

Notes Section:

a You have 46 full days remaining in this benefit period.
b $766.00 was applied to your inpatient deductable.

(16)

Deductable information:

You have met the Part A deductable for this benefit period.

(17)

General Information:

If you were offered free items or services but medicare was billed, please call our Fraud Hotline at 1-800-XXX-XXXX.

(18)

Appeals Information - Part A (Inpatient)

If you disagree with any claims decision on Part A of this notice, you can request an appeal by August 16, 2000. Follow the instructions below:

Appeals Information - Part B (Outpatient)

If you disagree with any claims decision on Part B of this notice, you can request an appeal by December 16, 2000. Follow the instructions below:

1) Circle the item(s) you disagree with and explain why you disagree.

2) send this notice, or a copy, to the address in the "Customer Service Information" box on Page 1.

3) Sign here _____ Phone number (_____) _____

Medicare Summary Notice

How to Read Your Medicare Summary Notice

Inpatient and Outpatient Claims

The inpatient and outpatient notices have been replaced with a newly designed Medicare Summary Notice (MSN). Remember that the MSN is not a bill. DO NOT send money to Medicare or to the providers of service until you receive a bill.

---

1. The **Date** the MSN was sent.
2. Refer to the **Customer Service Information** box if you have questions about your MSN. For all inquiries, include your Medicare number, the date of the notice, and the specific date of service you have questions about.
3. **Your Medicare Number** should match the number on your Medicare card.
4. If your **Name and Address** are incorrect on your MSN, please contact both the Medicare intermediary shown on your MSN and the Social Security Administration immediately.
5. Read the **Help Stop Fraud** message for information on ways to protect yourself and Medicare against fraud and abuse.
6. **Part A Hospital Insurance - Inpatient Claims or Part B Medical Insurance - Outpatient Claims.** The Inpatient claims (for hospitals and skilled nursing facilities) and Outpatient claims are listed separately.
7. **Dates of Service** shows when services were provided. You may use these dates to compare with the dates shown on your hospital bill.
8. Each claim is assigned a **Claim Number**, which you may be asked to provide when calling regarding your MSN.
9. **Benefit Days Used** shows the number of days used in the benefit period. See the back of your MSN for an explanation of benefit periods.

   Note: For Part B Medical Insurance - Outpatient Facility Claims (not shown here), the column will be titled **Services Provided** *and will give a brief description of the service or supply provided.*

10. **Non-Covered Charges** shows the charges for services denied or excluded by the Medicare program for which you may be billed.
11. The amount applied to your **Deductible and Coinsurance.**
12. **You May Be Billed.** This is the total amount the provider is allowed to bill you. It combines the deductible, the coinsurance and any non-covered charges. If you have supplemental insurance, it may pay all or part of this amount.
13. **See Notes Section.** If a letter appears in this column, refer to Notes Section. Please see item 15 in this pamphlet.
14. **Provider's Name and Address** shows the name of the facility where you received services. The referring doctor's name will also be shown. The address shown is the billing address which may be different from where you receive the service(s).
15. The **Notes Section** gives more detailed information about your claim.
16. The **Deductible Information** section shows how much of your Part A and/or Part B deductible has been met.
17. The **General Information** section provides important Medicare news and information.
18. **Appeals Information,** such as how and when to request an appeal, is shown here. See the back of your MSN for more information and how to get help with the appeal requests.

NHIC Published by National Heritage Insurance Company Medicare Part B Carrier for Maine Massachusetts, New Hampshire Vermont and California

Examples of Medicare and Medicaid Fraud and Abuse

Fake Collector

An individual employed in a provider office copied an official Medicare letterhead and wrote letters to several providers claiming they owed money to Medicare. The mail payment address on the letterhead was a post office box rented by the individual. The individual also sent bills to Medicare for services that were never rendered. When the payments were received at the provider's office, the individual opened the mail and deposited the checks in his account. The provider was not involved in this scheme. The individual was prosecuted and found guilty of fraud.

Free Coupons

Coupons for "free" podiatry and optometry evaluations were delivered in coupon packages and delivered by mail to thousands of households. "Free" toenail trims and "free" eye exams were offered on the coupons. While at the provider's office, beneficiaries were asked for their Medicare number for record keeping purposes. Medicare was then billed for these "free" services under false codes and descriptions.

Oxygen Scam

Oxygen supply companies were going to nursing homes and senior centers and providing "free" oximetry tests (measures the amount of oxygen in the blood) to its residents. If the level of oxygen was normal, the beneficiaries are asked to climb up and down stairs several times until winded. The beneficiary is re-tested and usually fails the oximetry test. Oxygen is then prescribed and delivered to the beneficiary on an automatic basis by the oxygen company

Diabetic Supplies

Some diabetic supply companies perpetrate automatic re-order schemes. Diabetic supplies such as lancets and testing strips are regularly delivered to beneficiaries' homes. Supplies may not be used as fast as they arrive. Over ordered supplies are accumulated by the beneficiary and eventually dumped.

PART IV

MEDICAID WAIVER/MASSHEALTH

MEDICAID WAIVER PROGRAM

SUMMARY OF PROGRAM BENEFITS

AND

ENROLLMENT PROCEDURES

Prepared by the Coordination of Care and SHINE Insurance Counseling Units of the Executive Office of Elder Affairs
1 Ashburton Place, 5th Floor
Boston, MA 02108

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MEDICAID WAIVER PROGRAM SUMMARY

1. PROGRAM GOALS

The U.S. Dept. of Health and Human Services (HHS) can grant waivers to states to permit federal long term care Medicaid dollars to pay for community-based services that are cost-effective by preventing or reducing the use of nursing facility services. The Medicaid Waiver Program is available throughout Massachusetts through the Home Care Program Medicaid Waiver Program

The Medicaid Waiver Program seeks to:

1. provide increased revenue for community services in order to offer frail elders an alternative to institutionalization;
2. collect data to evaluate the effectiveness of community care; and
3. provide valuable information, which shapes, develops and improves public policy.

2. GENERAL DESCRIPTION OF THE MEDICAID WAIVER PROGRAM

Medicaid Waiver Program participants must be:

1. active Home Care or Respite Program clients,
2. financially eligible for Medicaid for both income and assets,
3. in need of at least one waivered service, and
4. medically eligible for nursing facility services.

Although financial eligibility for Medicaid is usually based on the combined income of both spouses in a family, there is a special provision under the Medicaid Waiver Program called the ***Spousal Waiver***. The ***Spousal Waiver*** allows elders to "waive" ("stand apart from") their spouse's income and assets, if necessary, to become eligible for Medicaid. So, if a couple is asset-eligible for Medicaid, each spouse may participate in the Medicaid Waiver Program by waiving each other's income. However, if the couple's combined assets are too high for community Medicaid, then they may consider transferring assets to one of them so as to make the other spouse both income **and** asset eligible for Medicaid.

Please Note: MassHealth can seek recovery from a Waiver Program client's probate estate for all costs paid on their behalf. MassHealth eligibility and recovery rules are very complex and may impact one's estate planning. A client may want to speak with an attorney or financial planner experienced in estate panning and MassHealth eligibility before making any decision about enrollment in any MassHealth program.

3. ELIGIBILITY CRITERIA

To participate in the Medicaid Waiver Program, the Home Care or Respite Program client or applicant must meet all four of the following eligibility criteria:

1. Eligible for either the Home Care or Respite Program (age, financial, and FIL);
2. Eligible for nursing facility services as outlined in the DMA regulations: 130 CMR 456.408 and the Elder Affairs Coordination of Care Manual;
3. Financially eligible for Medicaid (for Spousal Waiver, the participant is treated as a single person as their spouse's income is waived); and
4. In need of and receiving from the ASAP, a waivered service:

- Homemaker
- Personal Care
- Respite Care
- Enhanced Personal Care Services
- Supportive Home Care Aide
- Companionship Services
- Environmental Accessibility Adaptations
- Supportive Residential Care
- Chore Services
- Dementia Day Care
- Grocery Shopping/Delivery Services
- Home-Delivered Meals
- Laundry Services
- Social Day Care Services
- Transportation

4. EXAMPLES

Example #1 - MEDICAID WAIVER: A current or new applicant Home Care or Respite Program client is in need of (or is already receiving) a waivered service. In addition, this elder meets medical eligibility for nursing facility services, and will meet (or has already applied and met) Medicaid's financial eligibility criteria.

Example #2 - SPOUSAL WAIVER: A current Home Care or Respite Program case (husband/wife) with combined income under the Cost Sharing Program. The husband needs at least one waivered service and meets medical eligibility criteria for nursing facility services. The individual income of the husband is below the maximum income for a single person under the DMA financial eligibility criteria. Their combined countable assets are less than

$3,000. He may enroll into Medicaid and the Medicaid Spousal Waiver Program.

Example #3 - SPOUSAL WAIVER: A couple's combined income is above the maximum income guidelines for the Home Care and/or Respite Program. However, the wife is medically eligible for nursing facility services and in need of at least one waivered service to remain at home. Her individual income is below the maximum income for a single person under the DMA financial eligibility criteria. But, there combined countable assets of $40,000 far exceed the income level of $3,000 permitted for community residents applying for Medicaid. She consults with MassHealth and her estate-planning attorney. She decides to transfer her claim to certain assets so as to keep only $2,000 in her name, thus becoming asset-eligible too. She then may acquire MassHealth as a enrollee in the Medicaid Waiver Program.

5. MEDICAID WAIVER ENROLLMENT PROCEDURES

1. The ASAP staff identifies Home Care or Respite clients or new applicants who are receiving or are in need of (and willing to receive) at least one waivered service.

2. The ASAP staff give to the client or new applicant written notification of their intent to refer them to the Medicaid Waiver Program.

3. A medical screening is conducted by an ASAP RN to determine medical eligibility for nursing facility services. They send a notification of medical eligibility and a Request for Fair Hearing form to the client.

4. If the elder and/or spouse is not currently a Medicaid recipient, a Community Medicaid application must be submitted to the MassHealth Enrollment Center (MEC). The Community Medicaid application should be sent in at the same time that the medical eligibility determination for nursing facility services is completed by the ASAP RN. The local MEC determines eligibility for Community Medicaid.

5. For Medicaid Spousal Waiver applicants, the ASAP must also submit a letter to the MEC office along with the Community Medicaid application which states that the elder is currently receiving or is eligible (pending Medicaid approval) for waivered services under the Home Care or Respite Program.

6. Written notification that the client is clinically eligible for nursing facility services and that the client has the right to choose to receive those services in their home or community as an alternative to a nursing facility is issued to the client/applicant. This form must be signed by the client and returned to the

ASAP, and entered into the case file. This form is completed only at the completion of initial Medicaid Waiver assessment.

7. **Special Note**: If an applicant to the Home Care and/or Respite Program has recently been discharged from a nursing facility with Long Term Care Medicaid, community Medicaid status must be determined by calling the MEC's automated system at 1-800-554-0042. To access the system, the recipient's card numbers, effective date of service and provider number is needed.

6. INELIGIBILITY FOR THE MEDICAID WAIVER PROGRAM

Participants are ineligible for the Medicaid or Spousal Waiver Program when at least one of the following have been determined:

1. Ineligibility for either the Home Care or Respite Program;
2. No need of a waivered service;
3. Not receiving any waivered services (e.g. elder refuses waivered services);
4. Financial ineligibility for Medicaid; or
5. Medical ineligibility for nursing facility services.

7. PROGRAM COORDINATION

Implementation of the Medicaid Waiver Program requires the cooperation of the following agencies:

1. The Division of Medical Assistance (DMA) is responsible to HCFA for the administration of the Medicaid Waiver Program. DMA determines the financial eligibility for Medicaid clients and maintains a client data system.

2. The Executive Office of Elder Affairs (Elder Affairs) is responsible for program management (delegated by DMA) including billing for federal reimbursement.

3. The Aging Services Access Points (ASAPs) are responsible for determining medical eligibility for nursing facility services, assessing needs, applying to MassHealth, service planning and monitoring, and reporting client data to DMA and Elder Affairs.

8. ONGOING CASE MANAGEMENT AND ANNUAL REASSESSMENT FOR THE MEDICAID WAIVER PROGRAM

All Medicaid Waiver participants must be reassessed annually to establish continued Program eligibility. The reassessment process includes:

1. determining continuing medical eligibility for nursing facility services;
2. verifying that the client is still a Medicaid recipient;
3. determining that the client is still in need of and receiving a waivered service.

9. FOR MORE INFORMATION

Please consult the full ***Commonwealth of Massachusetts Home and Community-Based Medicaid Waiver Manual (July 1999 edition)*** for additional information about:

- ASAP procedures and forms
- how to reduce or terminate waiver services
- the client's appeals rights and procedures

The Commonwealth of Massachusetts
Executive Office of Elder Affairs
One Ashburton Place, Boston, MA 02108

JANE SWIFT
GOVERNOR

LILLIAN GLICKMAN
SECRETARY

Phone (617) 727-7750
Fax (617) 727-9368
TTY/TTD 1-800-872-0166

FACT SHEET #3

MassHealth Standard Health Insurance for Elders and The Medicare Savings Programs

MassHealth has many programs for Medicare beneficiaries whose income and assets meet financial guidelines.

If your income and assets are near or below these guidelines, contact a **MassHealth Enrollment Center at 1-888-665-9993 (TTY: 1-800-596-1272)** and ask for an application.

Contact the **Serving the Health Information Needs of Elders (SHINE) Program** at **1-800-AGE-INFO (1-800-243-4636) (TTY: 1-800-872-0166)** or your local Council on Aging to schedule an appointment for help in completing the application.

Medicaid and Medicare Combined

Individuals who have both Medicare and Standard Medicaid have full health insurance coverage. In addition to paying for all of the Medicare co-payments and deductibles, Medicaid also provides for full drug benefits, dentistry, eyeglasses, hearing aids, attendance at adult day health programs and medical transportation when necessary.

Medicaid – Medicaid offers **MassHealth Standard Health Insurance** for adults aged 65 or older who have income and assets within these financial guidelines:

Income & Assets: $736/month in income for individual with assets at or below $2,000
$988/month in income for couple with assets at or below $3,000

Adults with disabilities under the age of 65 may also enroll in a MassHealth insurance plan. No asset limits and higher income limits are used for adults with disabilities under the age of 65. Please call MassHealth for more information.

Medicare Savings Programs - (3)

Through three different programs, MassHealth can pay for all the "gaps" in Medicare coverage or just the Medicare premiums. These savings programs could save you a lot of money!

1. **Qualified Medicare Beneficiary Savings Program (QMB):** MassHealth pays for your Medicare Part B premium (and Part A premium too if you do not receive Part A *premium-free*), Part B co-payments (like the 20% for most physician services) and deductibles associated with Medicare.

Income & Assets: $736/month in income for individual with assets at or below $4,000
$988/month in income for couple with assets at or below $6,000

2. **Specified Low-Income Medicare Beneficiary (SLMB) Savings Program** and the **Qualifying Individual 1 (QI-1) Savings Program–**
Under both programs, MassHealth will pay your monthly Medicare Part B premium. If you enroll in 2001, you can save $600 for the year because MassHealth will pay the Part B premium for you!

Income & Assets: $987/month in income for individual with assets $4,000
$1,327/month in income for couple with assets $6,000

3. **Qualifying Individual 2 (QI-2) Savings Program:**
Under this program, MassHealth pays a small portion of the Medicare Part B premium (total value of benefit is $37.08 for 2001).

Income & Assets: $1,273/month in income for individual with assets at or below $4,000
$1,714/month in income for couple with assets at or below $6,000

Which Application Is Used for Each Program?

Contact a **MassHealth Enrollment Center at 1-888-665-9993 (TTY: 1-800-596-1272)** and ask for the application you want.

- For **Medicaid**, and the **Qualified Medicare Beneficiary Savings Program** Program, ask for the **UNIV-1 Form.**
- For **SLMB QI-1 and QI-2**, ask for the **"Buy In Application"**.

Who Can Help Me Fill Out the Application?

You may call a MassHealth Enrollment Center with questions on how to fill out the forms.

Counselors in the **SHINE Counseling Program** know how to complete these forms, too. You can contact a SHINE Counselor by calling **1-800-AGE-INFO (1-800-243-4636) (TTY: 1-800-872-0166)** or your local Council on Aging. Ask to schedule an appointment for help in completing the application.

HEALTH INSURANCE ASSISTANCE FOR INDIVIDUALS 65 AND OVER
ELIGIBILITY TOOL - 2001

NAME:_____ **AGE:**_____ **FAMILY SIZE**_____ **DATE:**_____
TOTAL INDIVIDUAL/COUPLE INCOME_____
TOTAL INDIVIDUAL/COUPLE ASSETS_____
AGENCY REFERRED TO:_____ **AGENCY PHONE #**_____

If your income is at or below	If your assets are at or below	You may qualify for....
Individual $736/month Couple $988/month	Individual $2,000 Couple $3,000	**Medicaid**-Benefits include payment of Medicare premium(s), co-payments, deductibles, prescription medication, eyeglasses, hearing aids, dental, and more. Contact the MEC for an application. (If income higher than $736/$988 see Spend-Down Program below.)
Individual $522/month Couple $650/month	Individual $2,000 Couple $3,000	**Medicaid Spend-Down Program** – Once the spend-down (deductible) has been met, the beneficiary will receive all MassHealth benefits. For beneficiaries 65 and over, the spend-down must be met every 6 months. For beneficiaries under 65 a one-time spend-down is required, and a higher income standard is used (133% FPL). Contact MEC for application.
Individual $736/month Couple $988/month	Individual $4,000 Couple $6,000	**Qualified Medicare Beneficiary - QMB** Benefits: Payment of Medicare premium(s), co-payments, and deductibles.
Individual $879/month Couple $1,181/month	Individual $4,000 Couple $6,000	**Specified Low-Income Medicare Beneficiary – SLMB**. Benefit: Payment of Medicare Part B premium. Contact MEC for application.
Individual $987/month Couple $1,327/month	Individual $4,000 Couple $6,000	**Qualifying Individual –1 QI-1** Benefit: Pays the Medicare Part B premium. Contact MEC for an application.
Individual $1,273/month Couple $1,714/month	Individual $4,000 Couple $6,000	**Qualifying Individual-2 QI-2** Benefit: Pays a portion of the Part B premium. Contact MEC for application.
Individual $658.82/month Couple $997.72/month	Individual $2,000 Couple $3,000	**SSI-Full Cost of Living Housing Category**. Benefits: Extra income and MassHealth Medical Insurance. Contact Social Security to apply. Contact local COA for information and help with other benefits programs (i.e. Fuel Assistance, Food Stamp, etc.).
Individual $569.26/month Couple $997.72/month	Individual $2,000 Couple $3,000	**SSI-Shared Expenses Housing Category**
Individual $457.70 Couple $746.48	Individual $2,000 Couple $3,000	**SSI-Household of Another Housing Category**
$823.00/month per person	Individual $2,000 Couple $3,000	**SSI – Rest Home Housing Category**
$984.00/month per person	Individual $2,000 Couple $3,000	**SSI – Assisted Living Housing Category**
Individual $16,152/yr Couple $21,828/yr	No asset test	**Prescription Advantage** – Prescription drug benefit, no premium, no deductible. Unlimited drugs.
Individ. $16,153-42,960/yr Couple $21,829-58,056/yr	No asset test	**Prescription Advantage** – Premium range $12-82/mo. Deductible $100-500/yr. Yearly maximum out-of-pocket cost - $2000 or 10%of annual gross household income whichever is less.

MassHealth Enrollment Center (MEC)	1-888-665-9993	TTY: 1-888-665-9997
Social Security	1-800-772-1213	TTY: 1-800-325-0778
Prescription Advantage	1-800-AGE-INFO (1-800-243-4636)	TTY: 1-800-813-7787
SHINE Counseling	1-800-AGE-INFO (1-800-243-4636)	TTY: 1-800-872-0166

SHINE-Serving the Health /Information Needs of Elders
Updated: 4/1/01
Form T-1 2001

Documentation Required to Accompany Applications

Copies of important documents are needed to prove certain facts you declare on an application. The documentation needed varies with each program. The following list identifies what is required per program.

SSI, Medicaid and QMB Programs

- Copy of Medicare card
- Copy of all health insurance cards plus a copy of a recent premium bill
- Copy of the most recent bank statement or pass book
- Copy of Social Security award letter
- Copy of other monthly income checks such as pension or retirement check
- Copy of real estate tax bill, if you own real estate
- Copy of rent receipt or cancelled rent check, if applicable
- Copy of life insurance policy showing current cash surrender value
- Copy of payment book or finance statement for automobile, if applicable
- Copy of any other document showing the value of any other assets (such as bonds certificates, mutual funds, a pre-paid burial contract or burial plot)
- Copy of birth certificate

Medicare Buy In Programs: SLMB, QI-1 and QI-2

You can self-declare your income and assets. You are not required to submit any documents to prove your income or assets.

Prescription Advantage

For those over age 65, only income-related documents are required.

If you or anyone in your household has filed a federal income tax return within the past two (2) years, **send copies of your most recently filed tax returns for all members of your household that have filed**. Members of household include: you, your spouse if living with you, and your dependent children aged 18 and younger

If you or anyone in your household has not filed a federal income tax return within the past two (2) years, send copies of documents that verify income from the following sources if applicable: (See the Prescription Advantage Enrollment Form for the types of documents that should be submitted).

- Social Security
- Pension income
- Dividends and/or interest
- Full or part-time wages
- Rental income
- Unemployment benefit

For those under 65 who have a disability, proof of disability must be submitted in addition to the above income verification. See the Prescription Advantage Enrollment Form section on disability.

SHINE-Serving the Health /Information Needs of Elders
Updated: 4/1/01
Form T-1 2001

Application Denied Due to Excess Assets

If the application to MassHealth is rejected due to excess assets, the MassHealth workers can explain how they may spend down the excess assets and demonstrate to MassHealth their eligibility status.

Non-countable assets can include:

- An irrevocable funeral contract for burial: ownership of a life insurance policy with a surrender value over $1500 may be transferred to the funeral home. Funeral home directors can explain how this may be done.
- An irrevocable burial account at the bank for burial purposes.

Setting Up a Non-Countable Burial Contract

✓ **An applicant can work with the funeral director before applying to set up the non-countable burial contract. Often, the applicant will use the death benefit from their life insurance policy to pay for their future burial.**

A letter must first be sent to the life insurance company requesting the current cash surrender value of the life insurance policy. Also, the client should ask the insurance company to send an "Absolute Assignment Form". If the cash surrender value exceeds $1500, then the applicant may sign over the ownership of the life insurance policy to the funeral home. Making an absolute assignment is not the same as simply changing the beneficiary. The life insurance company has a specific form to make this assignment.

Setting Up A Non-Countable Burial Account at the Bank

Banks have burial accounts that can be labeled **irrevocable.** Usually, two names are put on the account. The maximum amount in the account when set up can be $1500-but the interest can grow untouched and not affect MassHealth eligibility. This process should not take long. It will require signatures but it can be done through the phone and mail.

Instructional Tips for Meeting a MassHealth Deductible (Spend-Down)

Application Denied Due to Excess Income

After someone applies for MassHealth, if MassHealth determines they are "over income", they may spend down excess income and become eligible for the balance of each 6 month period. The spend down of excess income must be spent on medically related materials and services.

- The applicant must <u>incur</u> the expense; this means they do not have to pay for a service but they must have an active bill awaiting payment.

- Medical expenses can include items that are clearly medical, such as drugs, or items that are paid for over the counter normally, such as diapers for incontinent adults, aspirin, a taxi ride to the doctor's office, etc.

    1. The Medicare Part B Premium for 6 months can be immediately applied toward the deductible.
    2. Likewise, the 6-month total health insurance premium for Medigap or Medicare HMOs can be used immediately.
    3. Medicare deductibles and copayments 20% or 50% can be used.
    4. Transportation to medical appointments.
    5. Adult Day Health Programs.
    6. Lifeline costs (Personal emergency response units).
    7. Vision care.
    8. Podiatry.
    9. Dental Care.
    10. Chiropractor care.
    11. Adult Foster Care Program.
    12. Remedial services:
        - Definition: non-medical services made necessary by the medical condition of the individuals
        - Example: installation of a ramp in the home of a person who uses a wheel chair
        - Need: condition must be documented by a competent medical authority

- The itemized receipts from those purchases must be mailed into the MassHealth Enrollment Center (MEC) where the person applied.

- The Social Security Number must be written onto each itemized receipt as well as the applicant's name.
- The receipts should be mailed to "The Traditional Ongoing Unit of the MEC where he/she applied with "Attn: Traditional Ongoing Unit" on the outside of the envelope.
- A note should be sent with the receipts stating "For completing the spend down process for _____ (name,) xxx-xx-xxxx(Social Security Number).

Once the deductible is met, the MEC will send out a notification letter informing the applicant of the date they became eligible for MassHealth.

- The date will probably be back-dated, so that MassHealth will pay for all bills that were incurred from that day forward.

✔ **For example: The itemized bills may have reached the $800 spend down target on September 15th. Therefore, the doctor seen at the neighborhood health center on September 20th can now submit a claim to MassHealth for reimbursement.**

- Beware: MassHealth will not reimburse the individual for expenses they already paid (in cash or by credit card) that exceed the spend-down amount. It is very important to keep an ongoing accounting of all the mailed receipts so the applicant will know how close he or she is to meeting the spend down target and acquiring MassHealth coverage.
- When someone has to repeat the spend down process, workers at ASAPs can call in on their behalf and check if the card is re-activated. Case Managers call the MassHealth Eligibility Verification System at 1-800-554-0042 to check if a card is valid again. Individual applicants can call the MassHealth Customer Service Center at 1-800-841-2900.

PART V

PRESCRIPTION ASSISTANCE

The Commonwealth of Massachusetts
Executive Office of Elder Affairs
One Ashburton Place, Boston, MA 02108

JANE SWIFT
GOVERNOR

LILLIAN GLICKMAN
SECRETARY

Phone (617) 727-7750
Fax (617) 727-9368
TTY/TTD 1-800-872-0166

FACT SHEET #4

Programs That Help You Buy Prescription Drugs

If you want help paying for your prescription medications there are several programs that may help you.

A. **Prescription Advantage** is an insurance plan sponsored by the Commonwealth of Massachusetts began on April 1, 2001. Prescription Advantage provides an unlimited drug benefit, including coverage for insulin and disposable insulin syringes and needles. As of April 1, 2001, to be eligible for the plan, you must be a Massachusetts resident who is not eligible for MassHealth benefits and is:

- Over 65 years of age; or
- An adult with disabilities under age 65 with a gross annual household income less than $16,152 (individual) or $21,828 (married couple) who works for pay less than 40 hours per month; or,
- Enrolled in the PHARMACY Program or the PHARMACY Program Plus as of March 31, 2001.

All enrollees of Prescription Advantage pay a monthly premium, yearly deductible and prescription co-payments based upon their annual household income. However, the Commonwealth of Massachusetts will pay the premiums and deductibles for individuals and couples with incomes less than $16,152 (individual) or $21,828 (married couple).

- The monthly premiums for the first year range between $15 and $82 per month.
- The deductibles for the first year range between $100 and $500.
- Stop-Loss Protection – Yearly maximum out-of-pocket costs paid by each enrollee for deductible and co-payments is the lesser of either $2,000 or 10% of the member's annual gross household income, whichever is less.
- You may join anytime within the first year. Thereafter, limited periods of enrollment may be established.
- **Call** 1-800-AGE-INFO (1-800-243-4636) (TTY: 1-877-610-0241 for the hearing and speech impaired) **for information and an enrollment form for Prescription Advantage.**

B. **Retiree Plans -** If you have a retiree health insurance plan, review the policy or contact your employer to find out if it includes a prescription drug benefit.

C. **Veteran's Benefits** – The VA can help any registered veteran obtain prescription drugs at reduced rates. To do so, you must be seen by a VA doctor. You may maintain your own doctors as well. Most prescriptions can be filled at a VA hospital or clinic. You pay a $2.00 co-payment for a 30-day supply. Contact any VA health care facility, your town's Veterans' Agent Office, or call 1-877-222-VETS (1-877-222-8387) for more information on how to receive medical services including prescription drugs from a VA health care facility.

D. **Medigap -** Medigap is private Medicare supplemental insurance. Medigap "Supplement 2" policies must include an unlimited prescription drug benefit. There is a $35 per quarter deductible. Then, the policy pays 100% for the cost of generic drugs and 80% for the cost of brand name prescriptions. Some Medigap plans also offer mail-order options for prescription drugs with lower cost-sharing amounts. (See SHINE Medigap chart.)

E. **HMOs** – HMOs provide members with limited prescription drug coverage. Contact the Medicare HMO plans in your area to find out about their quarterly prescription drug benefits. (See SHINE HMO chart).

F. **MassHealth** – MassHealth standard health insurance for elders pays for prescription drugs for elders aged 65+ who meet the income and asset guidelines. Contact the MassHealth Enrollment Center at 1-888-665-9993 (TTY: 1-800-596-1272) to request an application.

G. **Free Prescription Drug Program -** Many pharmaceutical companies offer free medication to individuals who cannot afford to buy all of their medications. Contact the SHINE Program at 1-800-AGE-INFO (1-800-243-4636) for information on how to apply.

H. **Discount Prices at Local Pharmacy, Mail Order Houses, and Discount Card Programs** – Shop around. Prices for prescription drugs can vary between local and mail order pharmacies. Your local pharmacy may give discounts to senior citizens. Find out by asking the pharmacist directly for a discount. A few discount card programs provide set discounts at participating pharmacies.

I. **MassMedLine** – Provides medication education to help relieve the burden of medication expenses. Staff will assist with the paper work associated with applying for the free prescription assistance programs offered by many pharmaceutical companies. Call 1-866-633-1617 (TTY users may call Mass Relay 711)

The Serving the Health Information Needs of Elders Program ("SHINE Program") of the Executive Office of Elder Affairs has 450 trained and certified SHINE Health Insurance Counselors who can help you compare and contrast these options. Please contact the SHINE Program at 1-800-AGE-INFO (1-800-243-4636) TTY: 1-800-872-0166 or your local Council on Aging to schedule a face-to-face meeting with a certified SHINE Counselor.

Publications are funded by a grant from CMS.

Prescription Advantage

Massachusetts, Now You're Covered.

FACT SHEET

Prescription Advantage is a prescription drug insurance plan available April 1, 2001. *Prescription Advantage* provides coverage to all Massachusetts elders aged 65 or older and younger people with qualified disabilities. The first state-sponsored prescription drug insurance plan in the nation, *Prescription Advantage* is backed by the Commonwealth of Massachusetts and administered by the Massachusetts Executive Office of Elder Affairs.

Key features:

- **Peace of mind knowing that there's a limit to out-of-pocket prescription drug costs.** A key benefit of *Prescription Advantage* is the peace of mind it provides against catastrophic drug costs. Once a participant has spent either $2,000 – or 10 percent of his or her gross annual household income (whichever is less) – for deductible and co-payments, *Prescription Advantage* covers the full cost of prescription drugs (including co-payments), no matter how high the costs, throughout the remainder of the plan year. Enrollees must continue to pay premiums.

- **Affordability.** Premium, deductible and co-payment amounts are graduated based on gross annual household income.

- **Inclusivity**. Except for those covered by Medicaid (MassHealth, including CommonHealth), all Massachusetts residents 65 or older, regardless of their income or the status of their health, and some younger residents with qualified disabilities are eligible for *Prescription Advantage*. Members in the PHARMACY Program and PHARMACY Program Plus are also eligible for *Prescription Advantage*.

- **Convenience.** Nearly all pharmacies across Massachusetts and the nation accept the *Prescription Advantage* card, enabling you to fill prescriptions almost anywhere. A cost-saving mail service is available for filling prescriptions for drugs that you take over an extended period. With the mail service, you can even order refills over the Internet or over the phone.

- **Most drugs are covered.** *Prescription Advantage* covers most prescription drugs, including insulin and disposable insulin syringes with needles.

Prescription Advantage is administered by the Massachusetts Executive Office of Elder Affairs.

1-800-AGE-INFO (243-4636) | TTY/TTD 1-877-610-0241 | www.800ageinfo.com

Eligibility:

You are eligible for *Prescription Advantage* if you are a resident of Massachusetts, are not eligible for MassHealth (including CommonHealth) and if you:

1) Are 65 years old or older; or
2) Are under age 65, have a qualified disability and have a gross annual household income of $16,152 or less for individuals or $21,828 or less for married couples, and either do not work or work 40 or fewer hours per month; or
3) Were enrolled in the PHARMACY Program or PHARMACY Program Plus as of March 31, 2001.

Premiums and Premium Assistance:

Prescription Advantage, like other insurance plans, requires that participants pay a premium to remain enrolled. However, *Prescription Advantage* premium rates are graduated based on gross annual household income. Residents with lower incomes pay lower monthly premiums than those with higher incomes. For example, beginning April 1, 2001 through March 31, 2002:

- A single person earning $16,152 or less annually or a married couple with an annual household income no greater than $21,828 pays no premium.

- A single person earning $42,961 or more will pay a monthly premium of $82, while a married couple earning $58,057 or more in combined income will each pay $66 monthly for coverage.

A rate schedule is printed in the plan's enrollment form.

Annual Deductibles and Co-Payments:

Prescription Advantage requires that each participant pay an annual deductible – an amount paid out-of-pocket for prescription drugs – before the plan begins to cover prescription drug costs.

The deductible amount is graduated based on gross annual household income. Deductibles range from $0 for low-income participants to $500 for those with higher incomes.

How to Enroll:

***Prescription Advantage* Enrollment Forms are available:**

1) By calling toll-free to 1-800-AGE-INFO (1-800-243-4636)
2) By teletypewriter (TTY) – toll-free – 1-877-610-0241 (for the deaf and hard of hearing)
3) By logging onto www.800ageinfo.com
4) By writing to: *Prescription Advantage*, P.O. Box 15153, Worcester, MA 01615-0153
5) At your local Council on Aging

Completed enrollment forms, along with copies of required documentation, must be sent to: *Prescription Advantage*, PO Box 15153, Worcester, MA 01615-0153.

PART VI

OTHER RESOURCES

Veteran's Health Care Benefits

When working with individuals it is always advisable to ask if they are a veteran. The Department of Veterans Affairs has a Uniform Benefits Package to assist veterans with their health care needs. Below are listed a few key points about these services. Veterans should be referred to the Veterans Agent in their community or they can call **1-877-222-VETS (1-877-222-8387)** to get more information on VA benefits.

- A veteran may apply for enrollment at any VA health care facility or veterans' benefit office at any time, in any year.
- Most veterans must be enrolled to receive VA health care.
- Once enrolled, most veterans will remain enrolled from year to year without further action on their part. However, certain veterans are required to provide income information to determine their priority level. These veterans will be mailed a VA Form 10-10 EZ, for completion, on an annual basis for re-enrollment.
- Veterans may choose not to be re-enrolled, or changes in VA funding may reduce the number of priority groups VA can enroll in a given fiscal year. Any veteran who is affected will be notified in writing.
- Should you have any changes in address, preferred facility, or other status information, you simply need to notify the VA location that has provided the care, the nearest VA health car facility, or dial the toll-free number **1-877-222-VETS (1-877-222-8387)**.
- For the first time, an enrolled veteran can receive a comprehensive health care package that is completely portable across the entire VA health care system.
- Enrollment levels are based on seven priority groups established by Congress.
- Comprehensive care includes medically indicated outpatient and inpatient services.
- Domiciliary care, nursing home care and dental care are not part of the Uniform Benefits Package, although some enrolled veterans may be eligible for these programs under other VA authorities.
- There is a new emphasis on preventive and primary care.
- Medications are covered by the program as long as they have been prescribed by a physician employed by or under contract with VA. Some veterans will be required to make a co-payment for prescriptions.
- Veterans are encouraged to retain any existing healthcare coverage they may already have.
- Veterans may choose their preferred facility for receiving preventive and primary care.

For more information on the Uniform Benefits Package, priority groups or the application process call toll-free 1-877-222-VETS (1-877-222-8387) or access information on the Internet at www.va.gov/health/elig

Benefits

What if the closest VA medical center (VAMC) does not have the services that I need?

If you are enrolled, the VA is responsible for providing you a full continuum of care. This called the Uniform Benefits Package. These services will be provided through your local VA, or at another VA facility. If the VA cannot provide the necessary medical care, they will arrange for you to receive care in your community at VA's expense.

If I enroll in VA, can I receive care anywhere in the VA system?

Yes. Once enrolled, you are part of a national health care system with approximately 1,100 locations of care. Generally, you will receive your preventive and primary health care at the VA location of care that you have indicated as your preferred facility. For more specialized treatment you may have a choice of locations as recommended by your primary care provider. When traveling you may obtain care at any VA location of care.

What benefits am I eligible for?

Veterans accepted for enrollment in the VA health care system will be eligible to receive necessary inpatient and outpatient services, including preventative and primary care. These include:

- Diagnostic and treatment services; rehabilitation
- Mental health, substance abuse and home health
- Respite and hospice care and
- Drugs in conjunction with VA treatment

Can I choose to get care outside of the VA system at VA cost?

Generally, no. By law, the VA is required to provide care within the VA system. There are certain special-category veterans, however, who may receive care outside the VA healthcare system at VA cost.

What benefits are not included?

The following services are not included:

- Non-FDA approved drugs
- Services not ordered and provided by a licensed and/or accredited professional staff
- Private duty nursing
- Cosmetic surgery
- Gender alterations
- Health clubs and spas
- In-vitro fertilization and similar procedures unless related to a service-connected condition

Can I get a prescription by a non-VA physician filled at the VA?

Only veterans with special eligibility, such as veterans in receipt of VA pension with aid and attendance benefits, are eligible to receive prescriptions at expense written by non-VA physicians.

What is the coverage for emergency services?

Urgent and limited emergency care services are available to enrolled veterans at VA health care facilities or non-VA health care facilities at which VA has a sharing agreement or contract. Only veterans with special eligibility may obtain emergency care, at VA expense, in a non-VA facility where VA does not have a sharing agreement or contract.

Are there any limits on days of care or outpatient visits VA will provide?

No. The veteran's primary care provider will determine what is appropriate and necessary hospital care or outpatient services and will provide such care consistent with current medical care practices.

Eligibility

Am I eligible for VA health care?

In order for you to be eligible for enrollment for healthcare, you must have:

- Been discharged from active military service under honorable conditions
- Served a minimum of 2years if discharged after September 7, 1980 (prior to this date there is no time limit)
- If a National Guardsmen or Reservist, served the entire period for which you were called to active duty other than for training purposes only

Am I eligible for Home Improvement Structural Alterations (HISA)?

Yes, all veterans are potentially eligible for HISA. However, benefits are limited to a dollar amount.

Am I eligible for travel benefits?

Travel benefits vary from veteran to veteran and depends on your specific situation.

If enrolled, can I get dental care?

In general, dental benefits are limited to service-connected dental conditions or to veterans who have a VA 100% service-connected disability rating.

Am I eligible for fee care?

All veterans are potentially eligible for fee basis care, however, the decision to utilize such care is left to the facility providing your care. By law, fee basis care can only be provided when your treating facility cannot provide you the care you require.

Am I eligible for a nursing home?

All veterans are eligible for nursing home care however, such care is provided based on available resources. Eligibility reform did not change eligibility requirements for nursing home care.

Am I eligible for free prescriptions?

If you are being provided treatment, necessary prescriptions will also be provided. A $2.00 copayment is charged for each prescription provided for the treatment of a nonservice-connected disability. Exemptions from this copayment requirement are provided for veterans service-connected 50% or more and for veterans whose income is less than the established dollar threshold.

Are women veterans eligible for unique benefits?

Women veterans are eligible for the same uniform benefit package as all veterans. Any care or treatment required which is not available at the preferred treatment facility will be obtained through other facilities or through community healthcare facilities.

What are the circumstances that a Coast Guard is eligible for enrollment?

Individuals who served in the Coast Guard are veterans and are eligible for VA health care benefits in the same manner as any other veteran who served in the Army, Navy, Marine Corps or Air Force.

What are the circumstances that a Merchant Marine is eligible for enrollment?

Certain Merchant Marines who served on U.S. flagged merchant ships between December 7, 1941 and August 5, 1945, may be eligible for enrollment for VA health care benefits. If you served between this period of time you should bring a copy of your DD214 "Discharge Certificate" to the nearest health care facility and they will review your eligibility with you.

Will I be seen for my nonservice-connected condition?

If you are enrolled, you will receive care that includes treatment for service-connected and nonservice-connected disabilities. Your physician will determine what is medically indicated and provide that care.

What is my service-connected percentage?

Service-connected disability ratings are under the jurisdiction of Veterans Benefits Administration (VBA). Contact with that office will need to be made in order to determine a veteran's current rating. If you have received care at a VA health care facility within the past couple of years, that facility will have a record of your rating.

Financial

Will I have to pay my insurance deductible?

You will NOT be responsible for any unpaid balance that the insurance carrier does not pay. In addition, many insurance companies will apply VA health care charges toward the satisfaction of their annual deductible.

Why do you need my spouse's insurance information?

We do this because some veterans are also covered under a spouse's insurance.

How come VA does not bill Medicare?

Law prohibits the VA from billing Medicare for care.

I don't have insurance, will VA still treat me?

Yes, whether a veteran has or does not have insurance plays no role in determining whether that individual is eligible for VA health care benefits.

Will you bill my insurance carrier?

If you are receiving care for a nonservice-connected disability and have health insurance, your insurance carrier will be billed. The VA does not bill your health insurance carrier for VA-adjudicated service-connected disabilities. (An adjudicated service-connected disability is one for which you have filed a claim and the VA has determined that you are service-connected)

I can't afford to make copayments. What do I do?

There are two options:

- The first option is to request a waiver for paying your current debt. If you request a waiver, you must submit sufficient proof that you can not financially afford to make payment to the VA. This process could take several months; please contact the Medical Care Cost Recovery Coordinator at the VA health care facility where you receive care.
- The second option is to request a hardship determination to avoid future debts. If you request a hardship, you are asking VA to change your status from a Category C to a Category A veteran. You will need to submit specific financial information about your current year income. A decision will be made based on information you provide.

How are copayments calculated?

There are three basic types of charges: medication, outpatient, and inpatient

- Medication – Prescription copayment charges were established by Congress, that charge is $2 for each 30 day or less supply of medication.
- Outpatient – The outpatient copayment established by Congress, was set at 20% of the current outpatient charge to third party health insurance carriers.
- Inpatient – Congress determined the appropriate inpatient copayment should be the current inpatient Medicare Deductible Rate plus $10 for each day you remain in the hospital.

The VA is currently submitting a proposal to congress to make copayment similar to those charged in the Veterans Local Community. For example if your local HMO would charge a $10 co-payment for an outpatient visit, the VA would also charge $10.

Do all of my copayments have to be paid at one time?

The VA would prefer your copayments be made all at one time. If this becomes a hardship for you the Medical Cost Recovery Coordinator at your local VA may establish payment plan for you.

What happens if I do not pay?

Several things could occur, the VA has the authority to submit a request to garnish your wages. The VA also has the authority to submit a request to offset you debt against your VA compensation benefits. Finally, the VA also has the authority to submit a request to the Internal Revenue Service, to offset your debt against any income tax refunds.

Can VA bill my insurance company for treatment of a service-connected disability?

No, they cannot.

Why should I tell VA my insurance information?

If you are a Priority 7 veteran, providing us your insurance information will allow us to bill your insurance carrier, which will offset part or all of your co-payment. The law requires the VA to bill private health insurance companies for all nonservice-connected care a veteran receives. The VA's budget and your future care could depend on the amount the VA is able to collect from private health insurance carriers. By not giving us insurance information you may be limiting your future care of many other veterans.

Enrollment

What is VA Health Care Enrollment?

VA health care enrollment is a new system providing you access to a comprehensive package of VA health care services. You just answer a few questions and are assigned by VA to one of the newly established priority groups. VA will send you a letter concerning your enrollment status.

Am I required to be enrolled?

You are required to be enrolled unless you are in one of the following categories:

- VA rates you as having a service-connected disability of 50% or more
- It has been less than one year since you were discharged from military service for a disability that the military determined was incurred or aggravated in the line of duty, and have not yet been rated by VA
- You are seeking care from VA for a service-connected disability only

Why should I enroll?

You should enroll to ensure that you will receive the comprehensive benefits package offered through VA's national health care system.

How long will I remain enrolled?

You will normally remain enrolled for one year. Enrollment will be reviewed and renewed each year depending upon your priority group and available resources. If VA cannot renew enrollment for another year, you will be notified in writing before their enrollment period expires.

If I move, how do I change my enrollment information?

You simply report any changes in enrollment information to your preferred facility or the VA health care facility nearest your home.

Is there a specific form I need to fill out to enroll?

Yes, if you want to use the VA healthcare system, you must fill out the enrollment application form (10-10 EZ). However, veterans needing treatment for a VA rated service-connected disability, a VA rated service-connected disability rated 50% or more, or released from active duty within the previous 12 months for a disability incurred or aggravated in the line of duty do not need to apply.

Do I need a new VIC (Veteran Identification Card) card now because of enrollment?

No, you do not need to change your VIC card.

How/where do I apply for health care?

You may apply for enrollment anytime during the year by completing an Application for Benefits VA Form 10-10 EZ. This form may be obtained by contacting your local VA health care facility, County Veteran Service Office (VSO), or Veteran Service Organization. Please complete and sign this form and forward to your nearest VA health care facility. Your application will be processed and forwarded to the VA Health Eligibility Center in Atlanta, GA. The Health Eligibility Center will notify you of your status.

What does preferred facility mean?

Your preferred facility designates where you prefer to receive your primary care is normally the facility closest to your home. However, acceptance in the VA healthcare system means that you may receive the comprehensive benefits package through the VA's national healthcare system at any VA healthcare facility you choose or are nearest to when you require care.

How do I change my preferred facility?

You can change your preferred facility at any time by simply notifying the Health Eligibility Center or any VA healthcare facility.

How does enrollment affect my fee-basis?

Enrollment does not affect your eligibility for fee-basis.

Should I give up my existing health care coverage if I enroll with VA?

No. You are allowed to keep your current health care coverage and are encouraged to do so. Veterans with private insurance or other coverage such as DoD, Medicare, or Medicaid may find these coverages to be a supplement to their VA enrollment. The use of other available health care coverage does not affect your enrollment status.

Will VA provide hearing aids and eyeglasses?

Generally, hearing aids and eyeglasses are not provided when the hearing and vision loss is the result of aging. However, if you are service-connected with a disability rating of 10% or greater they will be provided. Hearing aids and eyeglasses may also be provided in special circumstances.

OMB Approved No. 290
Estimated Burden Avg. 2

Department of Veterans Affairs

INSTRUCTIONS FOR COMPLETING APPLICATIONS FOR HEALTH BENEFITS

DEFINITIONS

SERVICE-CONNECTED: A veteran with a VA determination that an illness or injury was incurred or aggravated while on active duty

SERVICE-CONNECTED COMPENSABLE: A veteran who is paid VA monthly compensation for the service-connected disability.

SERVICE-CONNECTED NONCOMPENSABLE: A veteran who is rated 0% service-connected and not paid VA monthly compensati

NONSERVICE-CONNECTED: A veteran who does not have a VA determined service related condition.

SECTIONS TO COMPLETE

The checks (✓) in the table below indicate which Sections of the Application for Health Benefits should be completed by the applica
The Sections in the shaded blocks should be completed only if Section IIB is checked as "YES."

APPLICANT	SECTION						
	I	IIA	IIB	IIC	IID	IIE	III
0% SERVICE-CONNECTED, NONCOMPENSABLE	✓	✓	✓	✓	✓	✓	✓
0 TO 20% SERVICE-CONNECTED, COMPENSABLE	✓	✓	✓	✓	✓		✓
30 TO 40% SERVICE-CONNECTED, COMPENSABLE	✓	✓	✓	✓	✓		✓
50% OR GREATER, SERVICE-CONNECTED, COMPENSABLE	✓						✓
NONSERVICE-CONNECTED	✓	✓	✓	✓	✓	✓	✓
FORMER POW OR WWI VETERAN	✓	✓	✓	✓	✓		✓
NSC PENSION	✓						✓

SECTION I - GENERAL INFORMATION

Complete all questions if applying for Health Services, Nursing Home, Domiciliary or Dental benefits. Please edit all preprinted information and provide updated information. Skip all blocks with "N/A" or "For Future Use" preprinted in them.

SECTION II - FINANCIAL ASSESSMENT

The financial assessment is used to determine certain veterans' priority level for enrollment, possible exemption from co-payment requirements, and eligibility for total benefits. Veterans with a combined VA service-connected disability rating of 50% or greater and veterans in receipt of VA pension benefits are exempt from this assessment and should not complete this section.

SECTION IIA - DEPENDENT INFORMATION

If you answer YES in Section IIB. Complete Sections IIA, IIC, IID and IIE that apply to you. For example, if you are completing the form in June 1998, provide calendar year 1997 information. See table above for sections to complete.

SECTION IIB - FINANCIAL DISCLOSURE

Complete Section IIA if you answered YES in Section IIB. Use a separate sheet of paper for additional dependent children.

- You may count your spouse as your dependent even if you did not live together, as long as you contributed $600 or more in support
- Children under the age of 18 are not required to have attended school in order to be counted as a dependent.
- A child between the ages of 18 and 23 can only be counted as a dependent if they attend high school, or college or vocational school on a full or part time basis.
- Count child support contributions even if not paid in regular set amonts. Contributions can included tuition payments or payments of medical bills.

CONSENT TO RELEASE INFORMATION

I hereby authorize the Department of Veterans Affairs to disclose any such history, diagnostic and treatment information from my medical records (including information relating to the diagnosis, treatment of other therapy for the conditions of substance abuse, alcoholism or alcohol abuse, sickle cell anemia, or testing for or infection with the human immunodeficiency virus) to the contractor of any health plan contract under which I am apparently eligible for medical care or payment of the expense of care or to any other party against whom liability is asserted. I understand that I may revoke this authorization at any time, except to the extent that action has already been taken in reliance on it. Without my express revocation, this consent will automatically expire when all action arising from VA's claim for reimbursement for my medical care has been completed. I authorize payment of medical benefits to VA for any services for which payment is accepted.

SOCIAL SECURITY NUMBER	63	DATE OF BIRTH
SIGNATURE OF PATIENTS		DATE

SECTION IIC -PREVIOUS CALENDAR YEAR GROSS ANNUAL INCOME OF VETERAN, SPOUSE AND DEPENDENT CHILDREN

Complete Section IIC if you answered YES in Section IIB. Answer all questions. If the question does not apply or is not applicable, enter N/A. If you answer YES to Question 3, you will be provided additional forms to report your business expenses if your income (or combined income and net worth) exceeds the established threshold.

REPORT: All income BEFORE DEDUCTIONS for you and your spouse. Include:

- All wages, bonuses and tips, severance pay, or other accrued benefits (including gross income from your farm, ranch, property or business)
- Retirement and pension income
- Social Security Retirement income
- Social Security Disability income
- Compensation benefits such as: VA disability, unemployment, workers and black lung
- Cash gifts
- Interest and dividends, including tax exempt earnings
- Distributions from Individual Retirement Accounts (IRAs) or annuities
- Your child's unearned income information if it could have been used to pay you household expenses

DO NOT REPORT:

- Work income of dependent children attending high school, college, vocational rehabilitation or training
- Welfare or Supplemental Security Income (SSI) payments
- Payments from a government entity that are based on your financial need
- Profit from the occasional sale of property
- Income tax refunds
- Reinvested interest on Individual Retirement Accounts (IRAs)
- Scholarships and grants for school attendance
- Disaster relief payments or proceeds of casualty insurance
- Loans
- Agent Orange and Alaska Native Claim
- Settlement Acts income
- Payments to foster parents

SECTION IID - DEDUCTIBLE EXPENSES

Complete Section IID if you answered YES in Section IIB. Answer all questions. If the question does not apply or is not applicable, enter N/A. Nonreimbursed medical expenses include medical and dental care, drugs, eyeglasses, Medicare and medical insurance premiums, and other health care expenses. Do not list medical expenses if you expect to receive reimbursement from insurance or other sources.

SECTION IIE - NET WORTH

Complete Section IIE if you answered YES in Section IIB and you are a nonservice-connected veteran or a 0% service-connected noncompensable veteran. Do not complete this section if your gross household income, less deductible expenses, is above the threshold for the current year.

SECTION III - CONSENT AND SIGNATURE

ALL APPLICANTS MUST SIGN AND DATE THE APPLICATION FOR HEALTH BENEFITS.

The Paperwork Reduction Act of 1995 requires us to notify you that this information collection is in accordance with the clearance requirements of section 3507 of the Paperwork Reduction Act of 1995. We may not conduct or sponsor, and you are not required to respond to, a collection of information unless it displays a valid OMB number. We anticipate that the time expended by all individuals who must complete this form will average 20 minutes. This includes the time it will take to read instructions, gather the necessary facts and fill out the form.

Privacy Act Information: The VA is asking you to provide the information on this form under Title 38, United States Code, sections 1710, 1712, and 1722 in order for VA to determine your eligibility for medical benefits. The information you supply may be verified through a computer-matching program. VA may disclose the information that you put on the form as permitted by law. VA may make a "routine use" disclosure for: civil or criminal law enforcement, congressional communications, epidemiological or research studies, the collection of money owed to the United States, litigation in which the United States is a party or has an interest, the administration of VA programs and delivery of VA benefits, verification of identity and status, and personnel administration. You do not have to provide the information to VA, but if you don't, we will be unable to process your request and serve your medical needs. Failure to furnish the information will not have any affect on any other benefits to which you may be entitled. If you give VA you Social Security Number, VA will use it to administer your VA benefits, to identify veterans and persons claiming or receiving VA benefits and their records, and for other purposes authorized or required by law.

OMB Approved No. 2900-
Estimated Burden Avg. 20

Department of Veterans Affairs

APPLICATION FOR HEALTH BENEFITS

SECTION I - GENERAL INFORMATION

1A. TYPE OF BENEFIT(S) APPLIED FOR *(You may check more than one)*

☐ HEALTH SERVICES ☐ NURSING HOME ☐ DOMICILIARY ☐ DENTAL ☐ ENROLLMENT

1B. IF APPLYING FOR HEALTH SERVICES, WHICH VA MEDICAL CENTER OR OUTPATIENT CLINIC DO YOU PREFER

2. VETERAN'S NAME *(Last, First, MI)*	3. OTHER NAMES USED	4. GENDER *(Check one)* ☐ M ☐ F

5. SOCIAL SECURITY NUMBER	6. CLAIM NUMBER	7. DATE OF BIRTH *(mm/dd/yyyy)*	8. RELIGION

9A. CURRENT MAILING ADDRESS *(Street)*	9B. CITY	9C. STATE	9D. ZIP

9E. COUNTY	10. HOME TELEPHONE NUMBER	11. WORK TELEPHONE NUMBER
	( )	( )

12. CURRENT MARITAL STATUS *(Check one)*

☐ MARRIED ☐ NEVER MARRIED ☐ SEPARATED ☐ WIDOWED ☐ DIVORCED ☐ UNKNOWN

13A. LAST BRANCH OF SERVICE	13B. LAST ENTRY DATE	13C. LAST DISCHARGE DATE	13D. DISCHARGE TYPE	13E. MILITARY SERVICE NUMBER

14. CIRCLE YES OR NO

A. ARE YOU A FORMER PRISONER OF WAR	YES	NO	H. DO YOU HAVE A MILITARY DENTAL INJURY	YES	NO
B. DO YOU HAVE A VA SERVICE-CONNECTED RATING	YES	NO	I. DO YOU HAVE A SPINAL CORD INJURY	YES	NO
B1. IF YES, WHAT IS YOUR RATED PERCENTAGE.		%	J. ARE YOU ELIGIBLE FOR MEDICAID	YES	NO
C. ARE YOU RECEIVING A VA PENSION	YES	NO	K. ARE YOU ENROLLED IN MEDICARE HOSPITAL INSURANCE PART A	YES	NO
D. ARE YOU RETIRED FROM THE MILITARY	YES	NO	K1. EFFECTIVE DATE		
D1. WAS YOUR RETIREMENT THE RESULT OF A DISABILITY	YES	NO	L. ARE YOU ENROLLED IN MEDICARE HOSPITAL INSURANCE PART B	YES	NO
D2. WERE YOU REGULARLY RETIRED - (2D+yrs.)	YES	NO	L1. EFFECTIVE DATE		
E. WERE YOU EXPOSED TO TOXINS IN THE GULF WAR	YES	NO	M. MEDICARE CLAIM NUMBER		
F. WERE YOU EXPOSED TO AGENT ORANGE	YES	NO	N. NAME EXACTLY AS IT APPEARS ON YOUR MEDICARE CARD		
G. WERE YOU EXPOSED TO RADIATION	YES	NO			

15A. VETERAN'S EMPLOYMENT STATUS *(check one)*	15B. COMPANY NAME, ADDRESS AND TELEPHONE NUMBER
☐ NOT EMPLOYED ☐ EMPLOYED ☐ RETIRED *If employed or retired, complete item 15B* / / *Date of retirement*	

16A. SPOUSE'S EMPLOYMENT STATUS *(check one)*	16B. COMPANY NAME, ADDRESS AND TELEPHONE NUMBER
☐ NOT EMPLOYED ☐ EMPLOYED ☐ RETIRED *If employed or retired, complete item 16B* / / *Date of retirement*	

17A. VETERAN'S HEALTH INSURANCE COMPANY	18A. SPOUSE'S HEALTH INSURANCE COMPANY

17B. NAME OF POLICY HOLDER	18B. NAME OF POLICY HOLDER

17C. POLICY NUMBER	17D. GROUP CODE	18C. POLICY NUMBER	18D. GROUP CODE

19A. NAME, ADDRESS AND RELATIONSHIP OF NEXT OF KIN	19B. NEXT OF KIN'S HOME TELEPHONE NUMBER ( )
	19C. NEXT OF KIN'S WORK TELEPHONE NUMBER ( )

20A. NAME, ADDRESS AND RELATIONSHIP OF EMERGENCY CONTACT	20B. EMERGENCY CONTACT'S HOME TELEPHONE NUMBER ( )
	20C. EMERGENCY CONTACT'S WORK TELEPHONE NUMBER ( )

21. I DESIGNATE THE FOLLOWING INDIVIDUAL TO RECEIVE POSSESSION OF ALL MY PERSONAL PROPERTY LEFT ON PREMISES UNDER VA CONTROL AFTER MY DEPARTURE OR AT THE TIME OF MY DEATH. *(Check one)* ***(This does not constitute a will or transfer of title.)***

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☐ EMERGENCY CONTACT ☐ NEXT OF KIN

22A. IS NEED FOR CARE DUE TO ON THE JOB INJURY *(Check one)*	22B. IS NEED FOR CARE DUE TO ACCIDENT *(Check one)*
☐ YES ☐ NO	☐ YES ☐ NO

APPLICATION FOR HEALTH BENEFITS, Continued	VETERAN'S NAME	SOCIAL SECURITY NUMBER

SECTION II - FINANCIAL ASSESSMENT

IIA - DEPENDENT INFORMATION *(Use a separate sheet for additional dependents)*

1. SPOUSE'S NAME *(Last, First, MI)*	2. CHILD'S NAME *(Last, First, MI)*
3. SPOUSE'S SOCIAL SECURITY NUMBER	4. SPOUSE'S DATE OF BIRTH *(mm/dd/yyyy)*
5. CHILD'S DATE OF BIRTH *(mm/dd/yyyy)*	
6. SPOUSE'S ADDRESS *(Street, City, State, ZIP)*	7. CHILD'S SOCIAL SECURITY NUMBER
8. SPOUSE'S TELEPHONE NUMBER	9. CHILD'S RELATIONSHIP TO YOU *(Circle one)* Son Daughter Stepson Stepdaughter
10. DATE OF MARRIAGE *(mm/dd/yyyy)*	11. DATE CHILD BECAME YOUR DEPENDENT
12. IF YOUR SPOUSE OR DEPENDENT CHILD DID NOT LIVE WITH YOU LAST YEAR, ENTER THE AMOUNT YOU CONTRIBUTED TO THEIR SUPPORT SPOUSE $ CHILD $	13. EXPENSES PAID BY YOUR DEPENDENT CHILD FOR COLLEGE, VOCATIONAL REHABILITATION OR TRAINING *(tuition, books, materials, etc.)* $
14. WAS CHILD PERMANENTLY AND TOTALLY DISABLED BEFORE THE AGE OF 18? ☐ YES ☐ NO	15. IF CHILD IS BETWEEN 18 AND 23 YEARS OF AGE, DID CHILD ATTEND SCHOOL LAST CALENDAR YEAR? ☐ YES ☐ NO

IIB - FINANCIAL DISCLOSURE

You are not required to provide the financial information in this Section. However, current law may require VA to consider your household financial situation to determine your eligibility for enrollment and/or cost-free care of your nonservice-connected (NSC) conditions. If you are 0% SC noncompensable or NSC (and are not an Ex-POW, WWI veteran or VA pensioner) and your annual household income (or combined income and net worth) exceeds the established threshold, you must agree to pay VA co-payments for care of your NSC conditions to be eligible for enrollment. See Section III - Consent and Signature.

☐ **YES,** I WILL PROVIDE SPECIFIC INCOME AND/OR ASSET INFORMATION TO HAVE ELIGIBILITY FOR CARE DETERMINED. *Complete all sections below that apply to you with last calendar year's information. Sign and date the application.*

☐ **NO,** I DO NOT WISH TO PROVIDE MY DETAILED FINANCIAL INFORMATION. *I understand I will be assigned the appropriate enrollment priority based on nondisclosure of my financial information. By checking NO and signing below, I am agreeing to pay the applicable VA co-payment. Sign and date the application.*

IIC - PREVIOUS CALENDAR YEAR GROSS ANNUAL INCOME OF VETERAN, SPOUSE AND DEPENDENT CHILDREN

	VETERAN	SPOUSE	CHILDREN
1. WHAT WAS YOUR GROSS ANNUAL INCOME FROM EMPLOYMENT *(wages, bonuses, tips, etc.)*, AS WELL AS INCOME FROM YOUR FARM, RANCH, PROPERTY OR BUSINESS	$	$	$
2. LIST OTHER INCOME AMOUNTS *(Social Security, compensation, pension, interest, dividends) Exclude welfare.*	$	$	$
3. WAS INCOME FROM YOUR FARM, RANCH, PROPERTY OR BUSINESS *(If yes, refer to page 2, Section IIC of the instructions.)* ☐ YES ☐ NO			

IID - DEDUCTIBLE EXPENSES

1. NON-REIMBURSED MEDICAL EXPENSES PAID BY YOU OR YOUR SPOUSE *(payments for doctors, dentists, drugs, Medicare, health insurance, hospital and nursing home)*	$
2. AMOUNT YOU PAID LAST CALENDAR YEAR FOR FUNERAL AND BURIAL EXPENSES FOR YOUR DECEASED SPOUSE OR DEPENDENT CHILD *(Also enter spouse or child's information in Section IIA)*	$
3. AMOUNT YOU PAID LAST CALENDAR YEAR FOR YOUR COLLEGE OR VOCATIONAL EDUCATIONAL EXPENSES *(tuition, books, fees, materials, etc.) DO NOT LIST YOUR DEPENDENTS' EDUCATIONAL EXPENSES.*	$

IIE - NET WORTH

	VETERAN	SPOUSE
1. CASH, AMOUNT IN BANK ACCOUNTS *(Checking and savings accounts, certificates of deposit, individual retirement accounts, etc.)*	$	$
2. MARKET VALUE OF LAND AND BUILDINGS MINUS MORTGAGES AND LIENS. *Do not count your primary home. Include value of farm, ranch, or business assets.*	$	$
3. STOCKS AND BONDS AND VALUE OF OTHER PROPERTY OR ASSETS *(art, rare coins, etc.)* MINUS THE AMOUNT YOU OWE ON THESE ITEMS. *Exclude household effects and family vehicles.*	$	$

SECTION III - CONSENT AND SIGNATURE

CO-PAYMENT NOTICE: If you are a 0% service-connected noncompensable or a nonservice-connected veteran (and are not an Ex-POW, WWI veteran or VA pensioner) and your household income (or combined income and net worth) exceeds the established threshold, you may be eligible for enrollment only if you agree to pay VA co-payments for treatment of your NSC conditions. By signing this application you are agreeing to pay the applicable VA co-payment if required by law.

I CERTIFY THE FOREGOING STATEMENT(S) ARE TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE AND ABILITY.	DATE *(mm/dd/yyyy)*
SIGN HERE *(Signature of applicant or applicant's representative)*	

THE LAW PROVIDES SEVERE PENALTIES FOR WILLFUL SUBMISSION OF FALSE INFORMATION.

Ombudsman Programs-Elder Affairs -2001

MRI Activity	Long Term Care	Assisted Living	Community Care
Activity	The office of the State Ombudsman is responsible for establishing the policies and procedures of the Long Term Care Ombudsman Program, and for training and certifying all Ombudsman staff. The State Ombudsman **supervises local program operations, and provides technical assistance and support to local program staff.** She/he submits reports and recommendations on long term care Issues to the State Legislature and the Federal Administration on Aging. The State Ombudsman also interacts with other state agencies, such as the Department of Public Health, on complaint resolution and other long term care issues.	The purpose of the Assisted Living Ombudsman Program is to maintain or improve the quality of life for assisted living residents in the areas of health, safety, welfare or resident rights. The Assisted Living Ombudsman acts as a mediator and attempts to resolve problems or conflicts that arise between an assisted living facility and one or more of its residents. The Ombudsman serves as an advocate for resident rights, promoting the dignity, autonomy and respect of residents. Assisted Living residents and their families may call the Assisted Living Ombudsman Program for information and assistance, to register a complaint or to have a complaint investigated. Complaints may be brought on behalf of a specific resident or on behalf of residents as a whole.	The purpose of the Community Care Ombudsman Porgram is to assist elders and their families in the community by investigating and resolving their complaints. Covered community care programs include: programs of medical, functional or social support services that are provided to an individual living in their home, apartment, in a day care program, or a managed care demonstration program under the Social Security Act. Also covered would be home health services, community based Medicaid programs, the state home care funded program, and federally funded and private pay elder care programs specified.
Description	LTC operates 24 elder service program agencies throughout the state, located in Area Agencies on Aging, Aging Services Access Points, or in other local community agencies. The Ombudsman are trained to receive, investigate and resolve complaints made by, or on behalf of, residents of Nursing and Rest Homes; to protect residents' rights; to provide information on Long Term Care issues; and to advocate for positive changes to the Long-Term Care system.	The Ombudsman are trained to receive, investigate and resolve complaints made by, or on behalf of, residents of Assisted Living facilities; to protect residents' rights; and to provide information on Assisted Living issues.	The Community Care Ombudsman responds to inquiries from elders and their families, educates consumers about their rights and responsibilities, counsels consumers about concerns with their services, refers consumers to appropriate sources for help, and investigates and resolves complaints through mediation.

History of the Long Term Care Ombudsman Program

Ombudsman is a medieval Swedish word that means a representative of the people. An Ombudsman investigates complaints, reports findings, and helps to achieve settlements.

To understand our role, a brief understanding of how nursing homes evolved. Nursing homes are a fairly contemporary idea in the scope of total history. Until the 20th century, older people with no other caregivers were sent to almshouse, or poor farms.

With the advent of the Social Security in the 1930's, older people could use Social Security money to pay to live in private rooming houses, and institutions. Later amendments to Social Security provided assistance for people living in medical institutions as well. In 1950, the official status of nursing homes was recognized because amendments also required states to establish licensing standards for nursing homes.

Since then, nursing home growth exploded for several reasons: Medicare, Medicaid onset; Increase of people reaching 70+; decline of extended families; Increase of women in the work force – no longer home to be full time caretakers.

In 1971 in response to numerous reports, complaints and congressional hearings, Former President Nixon, developed an Eight Point Initiative to **improve the quality of care in Nursing Homes, establishing the groundwork for the Long-term care Ombudsman Program.**

In the early 70's Massachusetts received a grant to begin a pilot Ombudsman program.

Four Main Goals:

- **To receive, investigate and resolve complaints**, made by or on behalf of residents of nursing and rest homes.
- To **protect** residents rights
- To **provide** information
- To **advocate** for positive changes to the Long Term Care system.

Originally, the program designated one Ombudsman for the entire state, but after several years of operation, it was clear there was a more effective way to serve the needs of Massachusetts Nursing home population. This view was supported by the Older American Act, which required all states to have a Long Term Care Ombudsman program, creating a statutory level for the program. The redeveloped State Long Term Care Ombudsman Program began to develop local offices and train volunteer Ombudsman staff.

Presently, there are 24 local Ombudsman Programs that cover the commonwealth from Cape Cod to the Berkshires with more than 400 certified, active Ombudsman staff and volunteers.

Massachusetts, in 1983, passed the Massachusetts Ombudsman Access Legislation, which requires training and certification of each ombudsman and providing the right of access for local Ombudsmen to visit consenting residents between 10:00 am and 8:00 pm in every facility every day of the year.

Amendments to the OAA in 1987 called for an even broader role for the Ombudsman Program. These changes inspired the development of an Interagency Agreement between Executive Office of Elder Affairs and the Department of Public Health stating out joint efforts to coordinate and develop mutual cooperation.

In the recent reauthorization of the Older American Act, the Ombudsmen role was again emphasized, with the objectives still the same: To represent the needs and interests of present and potential long term care facility residents.

OLDER AMERICAN ACT: OMBUDSMAN PROGRAM

1. **Investigate and resolve** Long Term Care facility residents' complaints
2. Promote the **development of citizen organizations and train volunteers**
3. **Identify problems** through statewide reporting systems and passing on the info to appropriate public agencies
4. **Monitor the development and implementation of long-term care laws and policies at all levels**
5. **Gain access to facilities and to resident records**
6. **Protect confidentiality** of resident records, complainant identities and ombudsman files.

In review, the beginning ombudsman programs used a "lone ranger' sort of approach: investigating complaints, examining systemic problems and working to resolve both.

Then, the program evolved, with the State office becoming an administrator and program developer, with a growing number of local programs working to investigate complaints.

When OAA was authorized, the two roles were combined As the State Ombudsman retained program development responsibilities and was gain directed to investigate complaints and identify problems in the long term care system.

Massachusetts Organization:

Executive Office of Elder Affairs: STATE OFFICE:

- Ensures the program operates within federal and state laws and regulations.

  - TITLE III: Designate local operations to enable them to receive funds for program operation; and provides the ability to operate in accordance to OAA and the Ombudsman Access Law.
  - MGL 19A, provides local program staff legal access to LTC Facilities.
  - OAA gives the State Ombudsman the authority and responsibility to operate the Long Term Care Ombudsman Program. This means the Local Program Directors must maintain a continuous liaison to the state office.

- Designates local agencies to operate as official representatives of state office.
- Establish and policies and procedures to ensure local programs get technical support, training and skill development to assure delivery of quality service and assistance to residents of Long Term Care facilities.
- Trains, certifies and re-certifies local Program Directors, staff and Ombudsman volunteers
- Submits annual report, and recommendations on Long Term Care to MA legislature and Federal Administration on Aging.
- Interacts with state and federal agencies to assure the Rights of Residents are protected.
- Represents the interest of residents when state or federal policies are developed that affect the quality of care, life and environment in Long Term Care facilities.

LOCAL PROGRAMS:

- Operate in accordance with applicable state/federal laws and regulations.
- Develop a continuous liaison with the State Ombudsman office, the programmatic supervisor of all the local Program operations.

- Report to a designated supervisor in the Area Agency on Aging, handling all the personnel and employment policies concerning the local program.
- Operate with the directions and support of both the state and local Area Agency on Aging, as directed by the Older Americans Act.
- All Ombudsman Volunteers and paid staff report to the program director.
- Collect and forward statistics and information to the state office.

For further information about the Massachusetts Long Term Care Ombudsman Program, contact the Executive Office of Elder Affairs at 1-800-AGE INFO

Massachusetts Executive Office of Elder Affairs

Office of the State Long Term Care Ombudsman

↓

Designated Local Programs (Older Americans Act)

Local Program Director

↓

Ombudsman Program Staff and Volunteers

↓

Nursing Home and Rest Home Visitations
(Provide services to protect the health, safety, welfare and rights of residents)

PART VII
IMPORTANT TELEPHONE NUMBERS

The Commonwealth of Massachusetts
Executive Office of Elder Affairs

SHINE – Serving the Health Information Needs of Elders Counseling Program
One Ashburton Place, 5th Floor
Boston, MA 02108
Tel: 1-800-AGE-INFO (1-800-243-4636)
Out of State (617) 727-7750
TTY 800-872-0166

To Locate A SHINE Counselor In Your Local Area, Find the Area Number for your Town on the Index of Towns and then Match the Area Number with this List of Regional SHINE Programs.

Area #	Regional Program	Telephone
01	Berkshire County	800-957-3557 or 413-499-0524
02	Franklin and Hampshire County	800-498-4232 or 413-773-5555
03	Greater Springfield / Hampden Co.	413-750-2893
04	Worcester County	800-244-3032 or 508-852-5539
05	Framingham and Metro West	800-287-7284 or 508-872-1866
06	Foxboro / Canton Area	800-462-5221 or 781-784-4944
07	Danvers/North Shore	978-739-9002
08	Burlington/Cambridge/Somerville	781-272-7177
09	Greater Lawrence/Lowell	800-892-0890 or 978-683-7747
10	Malden/Chelsea/Revere	781-324-7705
11	Needham/Lexington/Brookline	617-964-5009
12	Quincy/Braintree/South Shore	617-376-1247
13	City of Boston	617-635-3995
14	Martha's Vineyard	800-334-9999
15	Plymouth County	800-231-1155
16	Attleboro/Fall River	800-987-2510
17	New Bedford	508-999-6400
18	Cape Cod/Nantucket	800-334-9999

Serving Health Information Needs of Elders (SHINE) Program

The SHINE Program is the health insurance counseling program for senior citizens and Medicare beneficiaries in Massachusetts administered by the Executive Office of Elder Affairs.

Shipping and Mailing Addresses, Telephone and Fax Numbers

Mary Kay Browne, SHINE Director — **617-222-7435**
Mary.K.Browne@state.ma.us

Marion Aspinall, SHINE Specialist — **617-222-7436**
Marion.G.Aspinall@state.ma.us

Richard Miranda, Curbing Abuse in Medicare Project — **617-222-7439**
Richard.Miranda@state.ma.us

Serving Health Information Needs of Elders Program — TTY 800-872-0166
Executive Office of Elder Affairs
1 Ashburton Place, 5th Floor
Boston, MA 02108-1518

FAX 617-727-9368

Regional Program Area Numbers, Coordinators And Telephone Numbers

WESTERN MASSACHUSETTS

AREA 1
BERKSHIRE CO.

SHINE Program — **413-499-0524**
Elder Services of Berkshire County — 800-957-3557
66 Wendell Avenue
Pittsfield, MA 01201 — Fax 413-442-6443

AREA 2
FRANKLIN & HAMPSHIRE COUNTIES

Lorraine York — **413-773-5555**
Franklin County Home Care — 800-498-4232
330 Montague City Road
Turners Falls, MA 01376 — Fax 413-772-1084

AREA 3 **HAMPDEN COUNTY** **Springfield COA**	**Gail Noe** Springfield Dept. of Elder Affairs 1600 East Columbus Ave Springfield, MA 01103	**413-750-2893** 413-750-2694 fax

CENTRAL MASSACHUETTS

AREA 4 **WORCESTER COUNTY** **CENTRAL MASS**	**Carole Goral** Central Mass Agency On Aging 360 West Boylston Street West Boylston, MA 01583	**800-244-3032** 508-852-5539 508-852-5425 fax
AREA 5 **BAYPATH** **Framingham**	**Patricia Parslow** BayPath Elder Services 354 Waverly Street Framingham, MA 01772	**800-287-7284** 508-872-1866 508-872-3325 fax
AREA 6 **HESSCO** **Foxboro**	**Peggy McDonough** Health and Social Services Consortium, Inc. 1 Merchant Street Sharon, MA 02067	**781-784-4944** 800-462-5221 781-784-4922 fax

NORTHEASTERN MASSAHCUSETTS

AREA 7		
DANVERS	**Helen Clinton**	**800-243-4636**
NORTH SHORE	Danvers COA	978-739-9002
	25 Stone Street	
	Danvers, MA 01923	978-762-0240 fax
AREA 8		
MINUTEMAN and		
Cambridge & Somerville	**Cynthia Phillips**	**781-272-7177**
	Minuteman Senior Services	
	24 Third Avenue	
	Burlington, MA 01803	781-229-6190 fax
AREA 9		
MERRIMACK VALLEY	**Francesca Yelton**	**978-683-7747**
Lawrence/Lowell	Elder Services of Merrimack Valley	800-892-0890
	360 Merrimack Street, Bldg. 5	
	Lawrence, MA 01843	978-687-1067 fax

AREA 10 **MYSTIC VALLEY &** **Chelsea, Revere,** **Winthrop**	**Susan Cripps** Mystic Valley Elder Services 300 Commercial Street 19 Riverview Business Park Malden, MA 02148	**781-324-7705** 781-324-1369 fax
AREA 11 **NEEDHAM** **West Suburban**	**Kenneth Levy** Needham COA 83 Pickering St. Needham, MA 02192-3122	**617-964-5009** 781-455-7599
AREA 12 **SOUTH SHORE** **Quincy**	**SHINE Director** Quincy COA Squantum Gardens 83 Saratoga Street Quincy, MA 02171	 617-376-1247 Fax - 617-376-1248
AREA 13 **BOSTON**	**SHINE Counselors/Community Service Advocates** Commission on Affairs of the Elderly Boston City Hall Boston, MA 02201	**617-635-3995** 617-635-3213 fax

AREA 14 **CAPE COD**	**Beth Fletcher** Chatham COA 193 Stoney Hill Road Chatham, MA 02633	**800-334-9999** 508-945-4796 508-945-5974 fax
AREA 15 **PLYMOUTH COUNTY** **Middleborough COA**	**Andrea Priest** Middleborough COA 558 Plymouth Street Middleborough, MA 02346	**800-231-1155** 508-946-2490 Fax - 508-946-2489
AREA 16 **ATTLEBORO**	**Lisa Sarkis** Attleboro COA Rev. Larson Senior Center 25 So. Main Street Attleboro, MA 02703	**800-987-2510** 508-222-1399 Fax 508-222-2581
AREA 17 **COASTLINE ELDER SERVICES** **Greater New Bedford**	**Carolyn Avery** Coastline Elderly Services. 1646 Purchase St. New Bedford, MA 02740	**508-999-6400** Fax 508-993-6510
AREA 18 **CAPE COD**	**Beth Fletcher** Chatham COA 193 Stoney Hill Road Chatham, MA 02633	**800-334-9999** 508-945-4796 508-945-5974 fax

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Jan. 2001

SHINE PROGRAM
INDEX OF AREA NUMBERS AND TOWNS

(Find the city you live in and its area. Then look up the Regional SHINE Program from the list.)

Area #	City / Town
15	Abington
08	Acton
17	Acushnet
01	Adams
03	Agawam
01	Alford
13	Allston
09	Amesbury
02	Amherst
09	Andover
08	Arlington
04	Ashburnham
04	Ashby
02	Ashfield
05	Ashland
02	Athol
16	Attleboro
04	Auburn
06	Avon
04	Ayer
18	Barnstable
04	Barre
01	Becket
08	Bedford
02	Belchertown
04	Bellingham
11	Belmont
16	Berkley
04	Berlin
02	Bernardston
07	Beverly
09	Billerica
04	Blackstone
03	Blandford
13	Boston
18	Bourne
09	Boxboro
08	Boxborough
04	Boylston
12	Braintree
18	Brewster
15	Bridgewater
13	Brighton
15	Brockton
04	Brookfield
11	Brookline

Area #	City / Town
02	Buckland
08	Burlington
08	Cambridge
06	Canton
08	Carlisle
15	Carver
18	Centerville
02	Charlemont
13	Charlestown
04	Charlton
18	Chatham
09	Chelmsford
10	Chelsea
01	Cheshire
03	Chester
02	Chesterfield
03	Chicopee
14	Chilmark
01	Clarksburg
04	Clinton
12	Cohasset
02	Colrain
08	Concord
02	Conway
02	Cummington
01	Dalton
07	Danvers
17	Dartmouth
11	Dedham
02	Deerfield
18	Dennis
16	Dighton
13	Dorchester
04	Douglas
11	Dover
09	Dracut
04	Dudley
09	Dunstable
12	Duxbury
13	East Boston
15	E. Bridgewater
04	E. Brookfield
03	E. Longmeadow
15	East Wareham

Area #	City / Town
18	Eastham
02	Easthampton
06	Easton
14	Edgartown
01	Egremont
02	Erving
07	Essex
10	Everett
17	Fairhaven
16	Fall River
18	Falmouth
04	Fitchburg
02	Florence
01	Florida
06	Foxboro
05	Framingham
04	Franklin
16	Freetown
04	Gardner
14	Gay Head
09	Georgetown
02	Gill
07	Gloucester
02	Goshen
17	Gosnold
04	Grafton
02	Granby
03	Granville
01	Gr. Barrington
02	Greenfield
04	Groton
09	Groveland
02	Hadley
15	Halifax
07	Hamilton
03	Hampden
01	Hancock
15	Hanover
15	Hanson
04	Hardwick
08	Harvard
18	Harwich
02	Hatfield
09	Haverhill

Area #	City / Town
02	Hawley
02	Haydenville
02	Heath
12	Hingham
01	Hinsdale
12	Holbrook
04	Holden
05	Holliston
03	Holyoke
04	Hopedale
05	Hopkinton
04	Hubbardston
05	Hudson
12	Hull
02	Huntington
18	Hyannis
13	Hyde Park
07	Ipswich
13	Jamaica Plain
15	Kingston
15	Lakeville
04	Lancaster
01	Lanesborough
09	Lawrence
01	Lee
02	Leeds
04	Leicester
01	Lenox
04	Leominster
02	Leverett
11	Lexington
02	Leyden
8	Lincoln
08	Littleton
03	Longmeadow
09	Lowell
03	Ludlow
04	Lunenburg
07	Lynn
07	Lynnfield
10	Malden
07	Manchester
16	Mansfield
07	Marblehead

Area #	City / Town
17	Marion
05	Marlborough
12	Marshfield
14	Martha's Viney.
18	Mashpee
13	Mattapan
17	Mattapoisett
08	Maynard
06	Medfield
10	Medford
04	Medway
07	Melrose
04	Mendon
09	Merrimack
09	Methuen
15	Middleborough
02	Middlefield
07	Middleton
04	Milford
04	Millbury
02	Millers Falls
04	Milleville
06	Millis
12	Milton
02	Monroe
03	Monson
02	Montague
01	Monterey
03	Montgomery
01	Mt. Washington
07	Nahant
18	Nantucket
05	Natick
11	Needham
01	New Ashford
17	New Bedford
04	New Braintree
01	New Marlborou.
02	New Salem
09	Newburyport
11	Newton
01	North Adams
09	North Andover
16	North Attleboro
04	N. Brookfield
18	North Chatham
16	North Dighton
10	North Reading
02	Northampton
05	Northborough
04	Northbridge
02	Northfield
16	Norton
12	Norwell
06	Norwood
14	Oak Bluffs
04	Oakham
02	Orange
18	Orleans
01	Otis
04	Oxford
03	Palmer
04	Paxton
07	Peabody
02	Pelham
15	Pembroke
04	Pepperell
01	Peru
02	Petersham
02	Phillipston
01	Pittsfield
02	Plainfield
06	Plainville
15	Plymouth
18	Pocasset
18	Provincetown
12	Quincy
12	Randolph
16	Rayham
07	Reading
16	Rehoboth
10	Revere
01	Richmond
17	Rochester
15	Rockland
07	Rockport
13	Roslindale
02	Rowe
09	Rowley
13	Roxbury
02	Royalston
03	Russell
04	Rutland
07	Salem
09	Salisbury
01	Sandisfield
18	Sandwich
07	Saugus
01	Savoy
12	Scituate
16	Seekonk
06	Sharon
01	Sheffield
02	Shelburne
05	Sherborn
04	Shirley
04	Shrewsbury
02	Shutesbury
02	South Deerfield
16	Somerset
08	Somerville
13	South Boston
12	South Braintree
17	So. Dartmouth
02	South Hadley
02	Southampton
05	Southborough
04	Southbridge
03	Southwick
04	Spencer
03	Springfield
04	Sterling
01	Stockbridge
10	Stoneham
06	Stoughton
08	Stow
04	Sturbridge
05	Sudbury
02	Sunderland
04	Sutton
07	Swampscott
16	Swansea
16	Taunton
04	Templeton
09	Tewskbury
14	Tisbury
03	Tolland
07	Topsfield
04	Townsend
18	Truro
02	Turners Falls
09	Tyngsborough
01	Tyringham
04	Upton
04	Uxbridge
07	Wakefield
06	Walpole
11	Waltham
02	Ware
15	Wareham
04	Warren
02	Warwick
01	Washington
11	Watertown
05	Wayland
04	Webster
05	Wellesley
18	Wellfleet
02	Wendall
07	Wenham
04	West Boylston
15	W. Bridgewater
04	West Brookfield
09	West Newbury
13	West Roxbury
03	W. Springfield
01	W. Stockbridge
14	West Tisbury
18	West Yarmouth
05	Westborough
03	Westfield
09	Westford
02	Westhampton
04	Westminster
11	Weston
16	Westport
06	Westwood
12	Weymouth
02	Whately
04	Whitinsville
15	Whitman
03	Wilbraham
02	Williamsburg
01	Williamstown
08	Wilmington
04	Winchendon
08	Winchester
01	Windsor
10	Winthrop
08	Woburn
04	Worcester
02	Worthington
06	Wrentham
18	Yarmouth

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State Health Insurance Assistance Program: Call for assistance with Medicare bills, questions on buying a Supplemental Insurance Policy or long term care insurance, dealing with payment denials or appeals, Medicare rights and protections, submitting complaints about your care or treatment, or for help choosing a Medicare health plan. ☎

ALABAMA 1-800-243-5463 or 1-334-242-5743	FLORIDA 1-800-963-5337 or 1-850-414-2060	KENTUCKY 1-800-372-2973 or 1-502-564-7372	MONTANA 1-406-444-7781 or 1-800-332-2272 (MT only)	OHIO 1-800-686-1578 or 1-614-644-3399	TEXAS 1-800-252-9240 or 1-512-424-6840
ALASKA 1-800-478-6065 or 1-907-269-3680	GEORGIA 1-800-669-8387	LOUISIANA 1-800-259-5301 or 1-504-342-0825	NEBRASKA 1-402-471-2201	OKLAHOMA 1-800-763-2828 or 1-405-521-6628	UTAH 1-800-439-3805 or 1-801-538-3910
AMERICAN SAMOA 1-808-586-7299	GUAM 1-808-586-7299	MAINE 1-800-750-5353	NEVADA 1-800-307-4444 or 1-702-486-4602	OREGON 1-800-722-4134 or 1-503-947-7250	VERMONT 1-800-642-5119
ARIZONA 1-800-432-4040 (AZ only) or 1-602-542-6595	HAWAII 1-808-586-7299	MARYLAND 1-800-243-3425 (MD only) or 1-410-767-1100 TTY: 1-410-767-1083	NEW HAMPSHIRE 1-800-852-3388 or 1-603-225-9000	PENNSYLVANIA 1-800-783-7067 or 1-717-783-8975	VIRGINIA 1-800-552-3402 or 1-804-662-9333
ARKANSAS 1-800-852-5494 or 1-501-371-2782	IDAHO 1-800-247-4422 (Boise) 1-800-488-5725 (Lewiston) 1-800-488-5731 (Twin Falls) 1-800-488-5764 (Pocatello)		NEW JERSEY 1-800-792-8820	PUERTO RICO 1-800-981-4355 or 1-787-721-8590	VIRGIN ISLANDS 1-809-778-6311 ext. 2338
CALIFORNIA 1-800-434-0222 (CA only) or 1-916-323-7315 (out of state)		MASSACHU-SETTS 1-800-882-2003	NEW MEXICO 1-800-432-2080 or 1-505-827-7640	RHODE ISLAND 1-800-322-2880 or 1-401-222-2880	WASHINGTON 1-800-397-4422 or 1-206-654-1833
COLORADO 1-800-544-9181 or 1-303-894-7499 ext. 356	ILLINOIS 1-800-548-9034 or 1-217-785-9021	MICHIGAN 1-800-803-7174	NEW YORK 1-800-333-4114 or 1-212-869-3850 (New York City)	SOUTH CAROLINA 1-800-868-9095 or 1-803-253-6177	WEST VIRGINIA 1-800-642-9004 or 1-304-558-3317
CONNECTICUT 1-800-994-9422	INDIANA 1-800-452-4800 or 1-317-233-3475	MINNESOTA 1-800-333-2433	NORTH CAROLINA 1-800-443-9354 or 1-919-733-0111	SOUTH DAKOTA 1-800-822-8804 1-605-773-3656 (Pierre) 1-605-336-9230 (Sioux Falls) 1-605-342-3494 (Rapid City)	WISCONSIN 1-800-242-1060 or 1-608-267-3201
DELAWARE 1-800-336-9500 or 1-302-739-6266	IOWA 1-800-351-4664	MISSISSIPPI 1-800-948-3090 or 1-601-359-4956	NORTH DAKOTA 1-800-247-0560 or 1-701-328-2977		WYOMING 1-800-856-4398 or 1-307-856-6880
DISTRICT OF COLUMBIA 1-202-676-3900	KANSAS 1-800-860-5260 or 1-316-337-7386	MISSOURI 1-800-390-3330 or 1-573-893-7900 ext. 137	NORTHERN MARIANA ISLANDS 1-808-586-7299	TENNESSEE 1-800-525-2816 or 1-615-741-4955	

*U.S. Government Printing Office 1998 — 455-395/81040

Medicare Telephone Numbers to Note

SHINE - Serving Health Information Needs Elders Health Insurance Counseling Program 1-800-AGE-INFO (1-800-243-4636) (TTY: 1-800-872-0166)	Free and objective health insurance **of** counseling program for Medicare beneficiaries and elders sponsored by the Mass. Executive Office of Elder Affairs.
Medicare Part B Carrier & State Fraud and Abuse Hotline 1-800-882-1228	Medicare Part B claims and coverage questions (except DME) as and fraud and abuse complaints.
Durable Medical Equipment (DME) Carrier 800-842-2052	Durable medical equipment claims and coverage questions.
Medicare Part A Intermediary 1-888-896-4997	Medicare Part A claims and coverage questions.
Mass Peer Review Organization 1-800-252-5533	Investigates complaints about poor quality of care received by a Medicare beneficiary from a Medicare HMO or any hospital, nursing facility or home health agency.
Centers for Medicare & Medicaid Services (CMS) Boston Regional Office Medicare Beneficiary Services 1-617-565-1232	Assistance for complex Medicare issues.
MassHealth for Medicaid, QMB, and SLMB And QI Programs 1-800-841-2900	Eligibility, applications and coverage information.
Medicare Advocacy Project 1-800-323-3205	Provides free advice and legal aid to Medicare beneficiaries.

National Medicare Fraud and Abuse Hotline 1-800-447-8477	Refers reports about Medicare fraud and abuse to Mass. Medicare carrier.
Social Security Administration 1-800-772-1213	Medicare enrollment; issues new Medicare cards.
Pharmacy Program 1-800-249-4696 1-800-AGE-INFO	Helps elders and adults with disabilities to buy prescription drugs.
Medicare Hotline 1-800-MEDICARE (1-800-633-4227)	Order publications
Dentistry for All 1-800-342-8747	Discount dentistry referral program.
MA Dept. of Public Health 1-800-462-5540	Investigates quality of care complaints and reviews hospital discharge planning by acute care hospitals.
Project Bread 1-800-645-8333	Food stamp applications

Internet Sites

www.medicare.gov - see the latest versions of Medicare publications about benefits and supplemental insurance options. Access Medicare Compare, a database of managed care plans sorted by zip code which provides benefits and quality of care information on local plans.

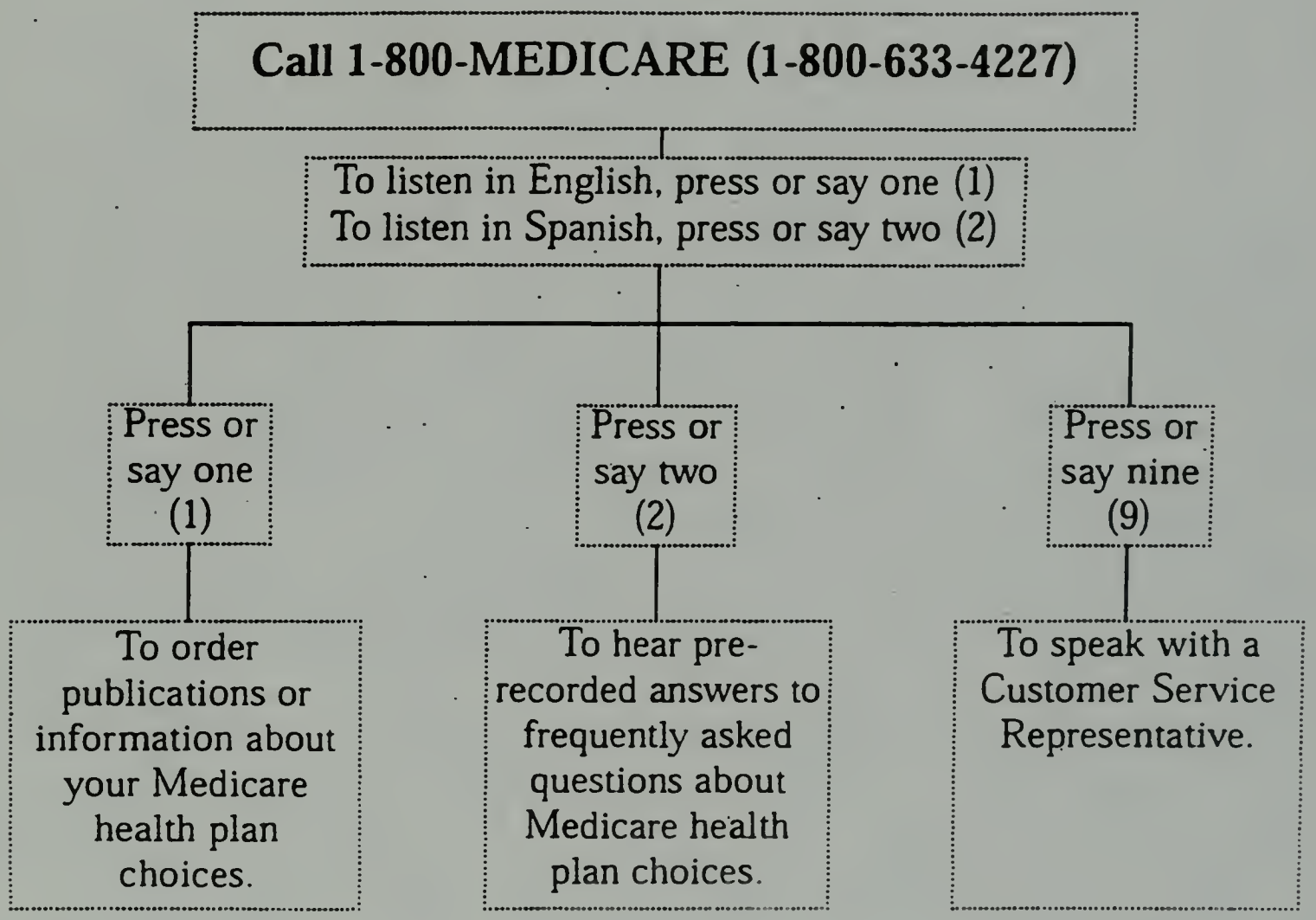
www.healthfinder.gov – this gateway site lists dozens of health-related sources, both governmental and non-governmental.

www.ncqa.org – the National Committee for Quality Assurance accredits managed care organizations and produces report cards evaluating the quality of care in individual plans.

www.state.ma.us\elder – Executive Office of Elder Affairs web site with some of the SHINE Health Insurance Counseling Program's most popular publications and consumer charts.

Call 1-800-MEDICARE to:

- Get more help with your questions about Medicare.
- Order Medicare publications. (Some are available in Spanish, audio-tape, and braille.)
- Order detailed information about the Medicare managed care plans in your area.
- Order Medicare health plan quality and customer satisfaction information.
- Listen to recorded questions and answers on topics such as Medicare health plan choices, and health plan quality information.



Important Facts About 1-800-MEDICARE

- If you are hearing or speech impaired, call our TTY/TDD line toll-free at 1-877-486-2048 for these options
- If you have a touch-tone phone, press the numbers listed. If you have a rotary phone, or if it is hard to dial, after you have dialed 1-800-633-4227 you can just say the numbers to request what you want.
- You can hear a recording with answers to frequently asked questions, and can order publications 24 hours a day, 7 days a week.
- You can talk with a Customer Service Representative between 8:00 a.m. and 4:30 p.m. in your time zone, Monday through Friday.